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An enquiry into the role of evidence in influencing the reconfiguration of stroke services in London

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*‘An enquiry into the role of evidence in
influencing the reconfiguration of stroke
services in London’*

**Thesis submitted by Alec Fraser to King’s College
London for examination: degree of Doctor of
Philosophy in Management Studies**

September 2014

Abstract

This thesis explores how changes in health service delivery are conceived of and pursued by different stakeholders. The thesis focuses on the importance of *evidence* to inform change. The London stroke service reconfiguration (2008-2011) is used as a case study to explore the interplay between evidence and the management of large-scale strategic change in health care. 45 semi-structured interviews were conducted with key stakeholders involved in the reconfiguration at both macro- and micro-levels through a pan-London case study with an embedded study at one London hospital affected by the reconfiguration. Observations of clinical meetings and analysis of official documentation was also performed. The study uses an ‘analytics of government’ (Dean, 2010) approach which is derived from Foucault’s (2007) work on ‘governmentality’ to interpretively explore the role of evidence in the reconfiguration process. This approach highlights the specific ways in which London’s stroke services were ‘problematised’ and explores the application of knowledge and techniques of power to address these issues. The discourse of evidence based health care is shown to be important in depoliticising potentially controversial strategic decisions. The advantages of conceptualising health service reconfigurations in ‘biopolitical’ terms are discussed. The impacts the reconfiguration had upon the relations between managers and professionals are analysed alongside a discussion around the interplay of disciplinary power and governmentality in the implementation of evidence based health care.

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Selected list of abbreviations

| | |
|---------|--|
| AHP | Allied Health Professional (Occupational therapist, Physiotherapist, Speech and language therapist, Dietician) |
| AHPF | Allied Health Professionals' Federation |
| AHRQ | Agency for Health care Research and Quality |
| ASI | Accelerating Stroke Improvement (programme) |
| A and E | Accident and Emergency (department) |
| BMJ | British Medical Journal |
| CAG | Clinical Advisory Group |
| CEO | Chief Executive Officer |
| CMS | Critical Management Studies |
| CT | Computerised Tomography (scan) |
| CVD | Cardiovascular Disease |
| DEG | Digital Era Governance |
| DGH | District General Hospital |
| DH | Department of Health |
| EBM | Evidence Based Medicine |
| EBHC | Evidence Based Health Care |
| EIS | European Implementation Score (project) |
| EUSI | European Stroke Initiative |
| FAST | Face Arm Speech Time (Stroke Awareness Campaign) |
| FT | Foundation Trust (hospital) |
| GDP | Gross Domestic Product |
| GP | General Practitioner |
| GSTT | Guys and St Thomas' Trust |

| | |
|-------|---|
| HASU | Hyper Acute Stroke Unit |
| HES | Hospital Episode Statistics |
| HQIP | Health care Quality Improvement Partnership |
| HMSO | Her Majesty's Stationery Office |
| ICSWP | Intercollegiate Stroke Working Party |
| JCPCT | Joint Committee of Primary Care Trusts |
| JHOSC | Joint Health Overview and Scrutiny Committee |
| KCL | King's College London |
| LA | London Assembly |
| LAS | London Ambulance Service |
| LCG | London Commissioning Group |
| LMDS | London Minimum Data Set |
| MP | Member of Parliament |
| MDT | Multi-Disciplinary Team |
| MRI | Magnetic Resonance Imaging (scan) |
| MRC | Medical Research Council |
| NAO | National Audit Office |
| NCAT | National Clinical Advisory Team |
| NHS | National Health Service |
| NINDS | National Institute of Neurological Disorders and Stroke |
| NICE | National Institute for Health and Care Excellence |
| NPM | New Public Management |
| NSSA | National Sentinel Stroke Audit |
| OECD | Organisation for Economic Cooperation and Development |
| OS | Organisation Studies |
| OT | Occupational Therapist |
| PCT | Primary Care Trust |

| | |
|-------|--|
| PEG | Programme Executive Group |
| PPI | Patient and Public Involvement |
| RCP | Royal College of Physicians |
| RCT | Randomised Controlled Trial |
| QI | Quality Improvement |
| QOF | Quality and Outcomes Framework |
| QUIPP | Quality, Innovation, Productivity and Prevention (programme) |
| SDO | Service Delivery and Organisation (programme of National Institute of Health Research) |
| SHA | Strategic Health Authority |
| SINAP | Stroke Improvement National Audit Programme |
| SLT | Speech and Language Therapist |
| SNS | Stroke Nurse Specialist |
| SpR | Specialist Registrar |
| SSNAP | Sentinel Stroke National Audit Programme |
| SU | Stroke Unit |
| SUTC | Stroke Unit Trialists' Collaboration |
| TIA | Transient Ischaemic Attack (mini-stroke) |
| VfM | Value for Money |
| WHO | World Health Organisation |
| WTE | Whole Time Equivalent |

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Chapter I

Introduction

1.1 Introduction; health care, evidence and politics

This thesis explores how changes in health service delivery are conceived of and pursued by different stakeholders. The thesis focuses on the importance of *evidence* to inform change. It is cognizant of the political nature of change in the NHS and the dynamic relationship between the forces of professionalism and managerialism in contemporary debates around how best to design and deliver twenty-first century health care. Health services face continual calls to change reflecting alterations in wider social, political and economic affairs. Much of this is led by demographic changes; as the make-up of societies evolve – for example due to aging or urbanisation, the health care structures designed to meet the needs and desires of one generation may come to be seen to fail to meet more contemporary needs. For example, the new District General Hospitals of the 1960s designed to solve the problems of the early post-war years have come to be seen as a barrier to the optimal health care delivery today (Ham, 2009). These developments are also linked to technological changes and modifications in how diseases are perceived and treated over time as understanding and evidence evolves and is challenged. Alongside changing demography and advancing technology sit policy developments and management reform instigated by different governments pursuing specific political agendas.

Decisions about whether, when and how to change health services are political – at both the macro-policy or national level and also lower local or regional levels where local interest groups consisting of patients, professionals and politicians frequently join forces to fight changes to established services (Spurgeon et al, 2010). The conflicting goals of different stakeholders and the non-conclusive nature of much clinical evidence frequently stymie efforts at reform leading to controversy, delays, stasis and underwhelming results (Oborn, 2010; Fulop et al, 2012). Attempts to de-politicise these decisions by citing scientific studies alongside mortality data and models showing economic benefits and travel time impact analyses frequently fail to mobilise sufficient public, professional or political support. For example, attempts at reconfiguring paediatric cardiac services have been consistently contested and challenged in the 13 years since the Kennedy Review of the Bristol Royal Infirmary deaths (Vize, 2013). Likewise, attempts to impose change from the centre as shown by the recent Lewisham case (Cooper, 2013) may fall foul of well organised opposition groups willing to challenge change through the courts.

Nevertheless, attempts at organisational change and service reconfiguration of and within the NHS persist. Whilst these changes may be more troublesome and delayed than many proponents might have hoped at the broad macro-level, the reality is that substantive change across NHS organisations does occur and permeates down into individual institutions, board rooms, wards and clinics. Since the Griffiths Report (1983) there has been a consistent governmental drive in England to increase professional accountability and the remit of management in the NHS (Hood, 1995; Ferlie et al, 1996; Newman, 2001). As managers' roles have increased in importance, and techniques of accountability, measurement and transparency (Power, 1999) have been emphasised progressively more within the public sector this has affected professionals' work and identities (Newman, 2001; Numerato et al,

2011). A key development has been the evolution of ‘hybrid’ professional-managers (Ferlie et al, 1996; McGivern, 2006) drawn from medical, nursing and AHP communities. A further structural concern has been the development of commissioning as a significant part of the health care establishment since the 1990s and the fluctuations between centralised networked strategic health care planning and more marketised, competitive models based on diversity of goals and providers (Hood, 1991; Dunleavy and Hood, 1994).

These political and organisational changes coincided with the rise of the evidence based medicine (EBM) movement since the mid-1990s (Timmermans and Berg, 2003) and evidence based practice and policy more broadly (Davies and Nutley, 2000) particularly through the New Labour era (1997-2010). EBM has impacted significantly upon health policy design and delivery, and how the *discourse* of how the need for change is framed – and by whom. For example, on the eve of the UK General Election in 2010, a group of fourteen medical leaders led by Neil Douglas, chair of the UK Academy of Medical Royal Colleges and Faculties wrote a letter to *The Guardian* stating that:

‘If the NHS is to cope with the financial pressures it is going to face under any government without resorting to indiscriminate and damaging service and staffing cuts, large-scale planned service redesign and reconfiguration based on *clinical evidence* [emphasis added] will have to be at the heart of the strategy.’ (Letter to *The Guardian*; 29/04/10)

This open letter to the next government displays a political agenda that seeks to influence the policy decisions of whichever party or parties would come to wield power over the English NHS after the 6th of May 2010. Simultaneously however, these senior clinicians use language that aims to pitch beyond traditional Left/Right political Discourse - the (financial) problem is clear, so too the dangers (indiscriminate and damaging service and staffing cuts) and the solution (large-scale planned service redesign and reconfiguration based on clinical evidence). The status quo of inaction is not an option, and potential public opposition must be challenged – however, these leading professionals are insistent that appropriate service reconfiguration must be driven by *clinical evidence* rather than the necessity of financial savings. The central message of the letter is that through the mobilisation of *clinical evidence*, the traditional political pitfalls of health service change may be avoided.

An interest in these broad policy and management issues led to the development of a specific research question focused on the interplay between evidence and the management of large-scale strategic change in health care. In contrast to the paediatric cardiology reconfiguration attempts (Vize, 2013); Kidderminster (Brown, 2003); Leicester (Parkinson, 2003); St Bartholomew's Hospital (Jones, 1993); Lewisham (Cooper, 2013); and indeed most other health care mergers and system redesigns (Spurgeon et al, 2010), the London stroke reconfiguration (2008-2011) has been welcomed as successful in both economic and clinical terms (Boseley, 2014). It has been well supported by political, managerial, professional and public or interest group stakeholders and is held up as a high profile, positive example of '*how to do a reconfiguration well*' by not only those who led the changes (NHS London, 2012), but also senior politicians (Burnham, 2013) and the press (Boseley, 2013; Barnes, 2014).

It was not necessarily clear when I chose to study the London stroke reconfiguration in September 2009 that it would be so warmly received as I sit writing here in 2014. Back then, the reconfiguration of stroke services across the capital faced significant challenges as it moved from a rather fractious phase in which different providers had bid against each other to be accredited to provide the new stroke services. However, as the study developed over time from 2009, it became apparent that as a case study of large scale service change, the London stroke reconfiguration may be considered a ‘positive outlier’ (Flyvbjerg, 2006). This makes this particular reconfiguration worthy of study with respect to both public policy and management fields – so, in practical terms, this thesis considers what lessons might be learnt (Rose, 1993) from this case study that may be useful for influencing policy and interpreting reconfigurations in the future.

Beyond this however, the present thesis seeks to develop theoretical knowledge as well as empirical understanding for four main reasons; firstly, listing reasons for ‘success’ (whilst not in itself a bad thing) is not particularly additive in theoretical terms – and indeed as will be discussed in chapter II section 5, a significant weakness of much of the literature produced that covers health care mergers and reconfigurations is that it tends to be theoretically weak (Fulop et al, 2012). Secondly, even given the ‘successful’ nature of these particular reforms, there were significant controversies and weaknesses which ought to be aired if the reconfiguration is to be more fully understood. This is particularly important given recent calls to ‘roll out’ the London model across other regions of the English NHS (Barnes, 2014, Boseley, 2014). Thirdly, a ‘critical’ approach to health care reform allows for an understanding that ‘successful’ policy solutions and management changes may have coercive,

or dangerous elements – rather than merely ask was it successful, and if so, why was it successful, this thesis also seeks to explore, *how* it was successful, for *whom* and also if any individuals or groups were harmed by it. Finally, conducting a case study of such a high profile and large scale reform programme with a particular focus on the role played by evidence and how it impacts upon key stakeholders offers a unique insight into important assumptions about the development of contemporary relationships between managers and professionals (Numerato et al, 2011) as health services undergo reforms.

For these reasons, a theoretical approach based on Foucault's work on 'Governmentality' (Foucault, 2007) was followed. This approach is fully discussed in chapter III. The approach is based around analysis of when, why and how policy makers 'problematise' particular issues in particular locations. For this thesis, the problem is stroke care in London circa 2007. The approach encourages the analyst to critically engage with the chosen topic and to challenge the 'taken for granted' nature of political change (Dean, 2010). Whilst the study is grounded in public policy, organisational studies and medical sociology literatures, it aims to build on recent applications of Foucauldian analyses to health care over the past decade or so (Doolin, 2004; Flynn, 2004; Sheaff et al, 2004; Waring, 2007; Ferlie et al, 2011; Martin et al, 2013). It is argued that the work of these scholars and their engagement with Foucauldian thought is particularly useful in explaining more about indirect control and the influence of Evidence Based Medicine (EBM) and increasingly Evidence Based Health Care (EBHC). Building on this literature, this thesis seeks to develop a theoretically additive understanding of how (clinical) evidence is deployed and interpreted by senior professional and managerial figures and how this may be seen to impact upon different professional jurisdictions (Abbott, 1988; Freidson, 2001; Timmermans and Berg, 2003).

Reflecting this theoretical stand point, the thesis is not primarily focused on an evaluation of the effectiveness of the reforms, or a judgement of the superiority or otherwise of the evidence behind them. Rather the thesis represents an interpretive exploration of what evidence means (and does) to different stakeholders at different times and how it is mobilised to achieve or negate aims which may be compatible or contradictory. This thesis is concerned with an interpretation of the ‘discourse’ of evidence based health care (and specifically evidence based stroke care) and how this is both *influenced by* stakeholders – for example through local level discursive practice; and also *influencing of* stakeholders’ actions as part of a broader ‘grand discourse.’ Alvesson and Kärreman (2000) note a tension between these analytic levels, and difficulty accounting for both within the same study – though counsel that this should not dissuade analysts from attempting to do so. They suggest that ambiguity around the term ‘discourse’ means that it often ‘comes close to standing for everything, and thus nothing’ (p.1128). For clarity, this thesis refers to ‘discourse’; firstly as the discursive practice of local actors in influencing contexts (Grint, 2005) to instantiate policy mandates for evidence based stroke care –termed little ‘d’ discourse (Alvesson and Kärreman, 2000). Secondly, big ‘D’ Discourse (Alvesson and Kärreman, 2000) refers to wider macro-level policy developments of evidence based stroke care – exemplified in national and regional policy documentation such as the National Stroke Strategy (DH, 2007) and the London Stroke Strategy (NHS London, 2008b). It is important to consider both forms of ‘discourse’ and how they inform practice.

The research question this thesis seeks to answer is:

What was the role played by evidence in the reconfiguration of stroke services in London?

A brief discussion of the international development of Evidence Based Medicine (EBM) and the domestic New Labour ‘evidence based policy’ context in which it developed in this country is needed to contextualise this research question. EBM emerged just over two decades ago as a comprehensively described entity (Guyatt et al, 2004). It was primarily a clinically and professionally led movement with origins in the UK and North America:

‘In essence, evidence based medicine is rooted in five linked ideas: firstly, clinical decisions should be based on the best available scientific evidence; secondly, the clinical problem—rather than habits or protocols--should determine the type of evidence to be sought; thirdly, identifying the best evidence means using epidemiological and biostatistical ways of thinking; fourthly, conclusions derived from identifying and critically appraising evidence are useful only if put into action in managing patients or making health care decisions; and, finally, performance should be constantly evaluated.’(Davidoff et al, 1995)

Professional self-surveillance, and an emphasis on scientific approaches to evaluating data sit at the heart of this approach – an extension of professionalism is inherent in this push to restructure knowledge sharing and maintain the autonomous position of the medical profession. Underlying this drive to EBM is a committed belief that traditional variations in clinical practice can no longer be tolerated (Chalmers, 2005).

‘Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.’ (Sackett et al, 1996)

A central concern of EBM, as highlighted by these two quotes is *standardisation* – the attempt to ensure that all medical professionals adhere to validated common principles and knowledge bases when treating patients – such a concern has political implications both within and beyond the profession (Timmermans and Berg, 2003). Timmermans and Berg (2003) place the EBM movement within the context of a wider historical push to increase uniformity and utilise standardised quality markers and processes which are streamlined with roots in the enlightenment belief in progress, rationality and organisational control linked with Weberian concepts of bureaucratic efficiency. This is linked to increasing medical complexity and specialist knowledge(s) and a fear that if the profession did not establish efficiency standards for themselves, then public officials might do it for them (Timmermans and Berg, 2003). Whilst this was a twentieth century phenomenon, it was only in the final years of the century that it became politically noticeable and potentially important. These years coincided with the rise of New Labour in the UK and the subordination of ideological commitment to ‘third-way’ pragmatism (Stoker 1999; Newman, 2001).

Nevertheless New Labour increased NHS spending after 1999. Overall, real expenditure as a percentage of GDP rose from 5.3% in 1997 to 8.4% in 2010 - in money terms public expenditure on health rose from £58.7 billion to £117.2 billion (Vizard and Obolenskaya, 2013). Alongside this, patient satisfaction in the service rose; there were significant advances in public health – notably the smoking ban, reductions in circulatory mortality, cancer mortality and a reduction in the infant mortality gap by social class (Vizard and Obolenskaya, 2013). However, significant variations in outcomes persisted across the service and there were serious failures of governance painfully highlighted by the scandal at the mid-Staffordshire NHS Trust (Vizard and Obolenskaya, 2013).

The New Labour governments also explicitly put measurement and evidence at the heart of their health policy; measurement most obviously in the form of targets and evidence most obviously with the establishment of the National Institute for Health and Care Excellence (NICE). NICE opened up decision making to public scrutiny and emphasised the utility and superiority of evidence as a tool to legitimise politically painful decisions. Together with the support of the Royal Colleges, the proliferation of guidelines along evidence informed best practice changed the delivery of health care through the New Labour years. New Labour took a strongly interventionist path with relation to attempting to improve health care outcomes in the UK – bench-marking itself against the best of the EU and North American competition with the goal tackling the areas where the UK has historically struggled – namely cancer and circulatory diseases. With the *NHS Plan* (DH 2000) the first two New Labour governments (1997-2001; 2001-2005) made heart disease reduction a priority along with cancer. The third New Labour government (2005-2010) included an increased interest in stroke care reform (Vizard and Obolenskaya, 2013). The following section introduces

important background information around what a stroke is, and how stroke care has developed over recent years.

1.2 Stroke

A stroke is an attack upon the brain which occurs when the blood supply to brain tissue is disrupted potentially causing infarction (which is tissue death due to a lack of oxygen). There are two distinct types of stroke; ischaemic (80% of cases), in which a blood clot causes a blockage in the supply of blood to the brain – potential causes are a cerebral thrombosis in which a blood clot forms in a major artery to the brain, alternatively a cerebral embolism in which a blood clot formed elsewhere in the body is transported to the brain, or finally, a *lacuna stroke* which is a blockage which forms within the tiny blood vessels inside the brain. The second type of stroke: haemorrhagic (20% of cases) are caused by bleeding on the brain following a burst blood vessel. There are two types of causality for this kind of stroke, either an intracerebral haemorrhage – in which a blood vessel within the brain bursts, or a subarachnoid haemorrhage – in which a blood vessel on the surface of the brain bleeds in to the area between the brain and the skull (Stroke Association, 2014).

Also of significance is Transient Ischaemic Attack (TIA). This is also known as a *mini stroke* and is less debilitating than a full blown stroke. Effectively, an area of the brain is starved of oxygen for a limited amount of time. There is evidence that TIA sufferers are at a higher risk of going on to develop further strokes in the future (Stroke Association, 2014). The risk factors for stroke increase with age. There is also evidence that black and Asian communities have higher incidences than white communities (Maheswaran, 1997). Finally, lifestyle factors

such as; smoking, inactivity, increased alcohol and salt intake, high cholesterol and obesity are all noted as increasing an individual's likelihood of suffering from a stroke (Stroke Association, 2014).

There are approximately 152,000 strokes in the UK each year. In 2010 stroke caused almost 50,000 deaths, making it the fourth largest cause of death (after cancer, heart disease and respiratory disease) and is attributable for 7% of male and 10% of female deaths respectively. There are over 1.1 million stroke survivors in the UK – more than half of whom are dependent upon others for everyday activities, making stroke the largest cause of disability in the country. More positively, the incidence of stroke is decreasing (Stroke Association, 2013). The economic costs however are considerable – estimated between £3.7 billion and £8 billion in 2010 (NAO, 2010; Stroke Association, 2014).

Whilst globally, stroke is and has been a significant cause of death and disability (Claiborne Johnston et al, 2009), until recently there was little public awareness of stroke, and few treatment options. Stroke was treated conservatively reflecting a perception of stroke as a natural phenomenon of ageing (Jordanova, 1995). Indeed the etymology of the term 'stroke' – which is traced back to the 1590s and '*the stroke of God's hand*' captures both the seemingly random nature of the event and the forceful blow which it imparts on those who suffer it (Pound et al, 1997). Parallel to this, the cause of stroke did not benefit from the support of a powerful group from within the medical profession –traditionally falling between care of the elderly physicians and neurologists neither of whom could offer much by the way of treatment until very recently – making stroke care somewhat of a *Cinderella service*.

Furthermore, the outlook amongst those who suffered and recovered from stroke tended to be

of acceptance and stoicism despite the debilitating nature of an attack (Pound et al, 1998). These elements of both fatalism and inevitability in the attitudes amongst stroke victims may have hindered any attempts to organise pressure on the authorities to improve the provision of stroke care. These factors may have historically kept stroke as an issue at a low level in terms of the health care agenda. However, this traditional picture has been challenged over recent years so that the medical view today is that stroke is both ‘a preventable and treatable disease’ (RCP, 2008). The 2008 collaborative guideline document produced by the Royal College of Physicians (RCP) and NICE states:

‘Over the last two decades, a growing body of *evidence* has overturned the traditional perception that stroke is simply a consequence of aging which inevitably results in death or severe disability. *Evidence* is accumulating for more effective primary and secondary prevention strategies, better recognition of people at highest risk and thus most in need of active intervention, interventions that are effective soon after the onset of symptoms, and an understanding of the processes of care that contribute to a better outcome. In addition, there is now good *evidence* to support interventions and care processes in stroke rehabilitation [emphasis added].’ (NICE, 2008)

It is worth noting the centrality of the word – *evidence* in the short extract above in the Discourse around transforming clinical perceptions relating to stroke. It is clear that both professionals and policy makers were very keen to present ‘evidence’ as being at the heart of this transformation in stroke care. We now have more evidence about what can cause stroke, what may prevent it, and the interventions which can reduce the impacts of both of these. As

life expectancy increases due to advances elsewhere in the health system, it makes more economic sense to limit the effects of stroke as much as possible (NAO, 2005).

The RCP has produced a bi-annual *National Sentinel Audit of Stroke for England Wales and Northern Ireland* since 1998. This includes data from all hospitals in the 3 nations which admit and treat stroke patients giving a comprehensive picture of the state of stroke care in the UK (excluding Scotland). The RCP also published *National Clinical Guidelines for Stroke* (2004), as well as the joint guidelines published with NICE in 2008. In addition, the Department of Health published a *National Service Framework for Older People* (2001) which promised improved access to better integrated stroke care, as well as a *National Stroke Strategy* (2007). The National Audit Office (NAO) has also produced two major documents focussing on quality and cost-effectiveness; *Reducing Brain Damage: faster access to better stroke care* (2005) and *Joining Forces to Deliver Improved Stroke Care* (2007). It is quite clear then, that in England; stroke has risen up the political, economic and clinical agendas over the last decade. Below is the key action plan taken from the 2007 Department of Health (DH) Stroke Strategy document:

Table 1

| <p style="text-align: center;"><i>National Stroke Strategy: Ten-point plan for action</i></p> <p style="text-align: center;"><i>(DH, 2007)</i></p> | |
|--|---|
| 1. | <i>Awareness:</i> improve public and professional awareness of stroke symptoms. |
| 2. | <i>Preventing stroke:</i> support healthier lifestyles and take action to tackle vascular risk, for example hypertension, atrial fibrillation and high cholesterol. |
| 3. | <i>Involvement:</i> involve people with stroke in their care planning. Involve those who have had a stroke in planning and evaluating local services. |
| 4. | <i>Acting on the warnings:</i> TIAs are a clear warning sign that a further stroke may occur and the time window for action is very short – in about half of cases, a matter of days. Put in place a system that responds quickly (within 24 hours) to people who have had a TIA. |
| 5. | <i>Stroke as a medical emergency:</i> get people quickly to the right hospital where there are specialists who can deliver acute treatments including thrombolysis. Ensure that everyone who could benefit from urgent care is transferred to an acute stroke centre that provides 24-hour access to scans and specialist stroke care. |
| 6. | <i>Stroke unit quality:</i> stroke unit care is the single biggest factor that can improve a person's outcomes following a stroke. Successful stroke units are built around a stroke-skilled multidisciplinary team that is able to meet the needs of the individuals. |
| 7. | <i>Rehabilitation and community support:</i> intensive rehabilitation immediately after stroke, operating across the seven-day week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or a care home, ensuring that health, social care and voluntary services together provide the long-term support people need as well as access to advocacy, care navigation, practical and peer support. |
| 8. | <i>Participation:</i> assistance to overcome physical, communication and psychological barriers to engage and participate in community activities helps people to lead more autonomous lives and move on after stroke. This will be across the range of community services – housing, education, leisure, transport, employment – that can help people to participate in community life again. |

9. Workforce: *people with stroke need to be treated by a skilled and competent workforce. Resources to assist services in planning their workforce requirements are signposted in this strategy.*

10. Service improvement: *this new vision for stroke care demands services working together in networks, looking across all aspects of the care pathway. Regular local and national audit and increased participation in clinical trials will also drive improvements in stroke care.*

Awareness and prevention are significant. This makes sense, as historically, those who suffered a stroke and (perhaps as importantly) their friends or relatives present at the time were unaware that their symptoms suggested stroke. A MORI poll commissioned by the Stroke Association suggested that 50% of the public were unaware of the symptoms of stroke and that less than 60% of GPs would immediately refer a suspected stroke victim to hospital (Leatherman et al, 2008). Hence the profusion of guidelines and policy documents for the clinical community and the ‘FAST’ public health advertising and warnings around salt intake, smoking, alcohol consumption and obesity in general.

Items 4-6 on the list deal with acute care responses. Essentially, health care providers have to be more aware of the clinical urgency of stroke and how services and practices can be changed to reflect this. Key here is treating TIAs seriously. Next, stroke patients must be recognised and prioritised in emergency care settings – radiological diagnostics need to be offered rapidly and clot busting drugs administered where appropriate (Wardlaw et al, 2005) in conjunction with timely admission to a dedicated stroke unit. Once admitted, the evidence shows that outcomes are improved when patients are treated on a stroke unit (SUTC, 2007.) It is worth detailing what we may understand by the term stroke unit. The Stroke Unit Trialists Collaboration (SUTC) defines a stroke unit thus:

‘Organised inpatient (stroke unit) care can be considered as a complex organisational intervention comprising multidisciplinary staffing providing a complex package of care to stroke patients in hospital.’(SUTC, 2007)

This is distinct from the traditional general medical ward treatment which may be viewed less positively in terms of effectiveness in relation to patient outcomes. Items 7-8 (taken from the National Stroke Strategy document) deal with short and long term rehabilitation factors. The final factors relate to staffing levels and the kind of changes in organisational management which the Darzi report of 2007, *A Framework for Action* (2007) outlines – specifically with reference to London. So the extent to which care is organised specifically for stroke patients differs across place and time.

These domestic political and clinical aspirations chime with European and global stroke care goals enunciated by the European Stroke Initiative (EUSI, 2000) and the World Health Organisation (WHO) Helsingborg Declaration of 2006 (Norrving, 2007). There is an international professional consensus as reported in these documents and papers around the key priorities to tackle stroke as a disease. Essentially these are; public awareness campaigns, increased medical acceptance of stroke as a treatable acute disease, access to high-tech scanning techniques as a priority allied to an awareness of the value of clot busting drugs and specialist ‘hyper-acute stroke unit’ care with dedicated multi-disciplinary teams and organised rehabilitation. Having touched upon the political role of evidence and the contemporary clinical consensus around stroke care and hinted at how epistemic communities may work with receptive governments to highlight areas which they desire to have an increased importance on the agenda, this chapter next focuses on how this affects London.

1.3 London

Health care reform in London has been characterised as ‘conflict without change’ (Smith, 1981). Introducing change to health care systems in any locality is frequently unpopular and contentious, as what *change* often equates to is *closure* (Spurgeon et al, 2010). Closing hospitals or rationalising services consistently runs in to opposition, however there are a number of contextual factors which exacerbate the situation in London even further, and a number of historical factors which have made reform in London even more pressing. These include the historical power of the most famous and prestigious London hospitals and the political power of their most senior consultants, the role of the media and the well-established local political groupings resistant to change. Key also has historically been the lack of a powerful central strategic force to forge consensus amongst competing parties (Pettigrew et al, 1992).

London has suffered from a number of deep seated problems which have led to numerous efforts to reconfigure the capital’s health care system (Appleby et al, 2011). Historically, these have included; too many acute beds, low standards of primary care, patchy specialist provision, a lack of funding for long term elderly care and poor coordination across the capital for London’s medical students (Appleby et al, 2011). The Tomlinson Report of 1992 highlighted the need for improved primary care and pointed to the high number of acute beds, recommending that numerous hospital sites be closed and Trusts be merged in order to fund the requisite improvements in the primary care sector (Rivett, 2013).

These recommendations faced a great deal of opprobrium typified by the *Save St Barts hospital* campaign (Jones, 1993). In 1997 Frank Dobson, Labour's first Health Secretary for close to two decades commissioned his own review of London's NHS and Medical Schools on gaining office – the Turnberg Report. Turnberg found that over 9,000 beds had been lost in London hospitals since 1990, and that further rationalisation was unjustified (Turnberg, 1997). A key recommendation from this report was that the health authorities (soon to become Strategic Health Authorities or SHAs) be divided in to five sectors as he called for greater strategic coherence in London health care planning (Rivett, 2013). In the years after 1999, NHS spending increased, but London's historic problems of poor strategic coordination and inadequate primary care remained.

In 2004 the decision was taken by the government to amalgamate the 5 London SHAs in to one strategic body representing the 31 London PCTs. In July 2006, NHS London came in to existence and Ara Darzi was asked to prepare a strategic report on London's health care future. Darzi's report was published a year later (NHS London, 2007). The remit of the review was to examine the contemporary problems of the NHS in London and set out a number of guiding principles to rectify these over the next five to ten years. The eight key drivers for change identified by Darzi are listed in Table 2, and the five principles which emerged from this work are listed in table 3:

Table 2

| <i>A Framework for Action (NHS London, 2007)</i> | |
|--|--|
| 1. | <i>The need to improve Londoners' health</i> |
| 2. | <i>The NHS is not meeting Londoners' expectations</i> |
| 3. | <i>One city, but big inequalities in health care</i> |
| 4. | <i>The hospital is not always the answer</i> |
| 5. | <i>The need for more specialised care</i> |
| 6. | <i>London should be at the cutting edge of medicine</i> |
| 7. | <i>Not using our workforce and buildings effectively</i> |
| 8. | <i>Making the best use of taxpayers' money</i> |

Table 3

| <i>A Framework for Action (NHS London, 2007)</i> | |
|--|--|
| 1. | <i>Services should be focused on individual needs and choices</i> |
| 2. | <i>Services should be localised where possible and regionalised where that improves the quality of care</i> |
| 3. | <i>There should be joined up care and partnership working, maximising the contribution of the entire workforce</i> |
| 4. | <i>Prevention is better than cure</i> |
| 5. | <i>There must be a focus on reducing differences in health and health care</i> |

With his London review, Darzi was attempting to tackle the historical problems London had faced. The review contained a commitment to reducing health inequalities and promoting disease prevention. The rhetoric of choice was maintained, whilst an implicit assumption made relating to the fact that people should be prepared to travel further for superior care for certain serious conditions, such as stroke (NHS London, 2007). Health care for London was an agency charged with leading strategic change across the capital under the rubric of NHS London. It was set up in 2007 and was funded by the 31 London PCTs and was closely linked with the SHA. Health care for London published its *Stroke Strategy for London* in November 2008 (NHS London, 2008b). This document explained that the approach is based on the *Framework for Action* findings combined with the 2007 *National Stroke Strategy*. The key conclusions of the document were that firstly, the quality of London's stroke care has improved at a slower rate than elsewhere in England and that this needs to be addressed.

Secondly, prevention needed to be taken more seriously and that problems such as high blood pressure must be tackled more effectively. Thirdly, clinical approaches to acute stroke care management need to be rethought:

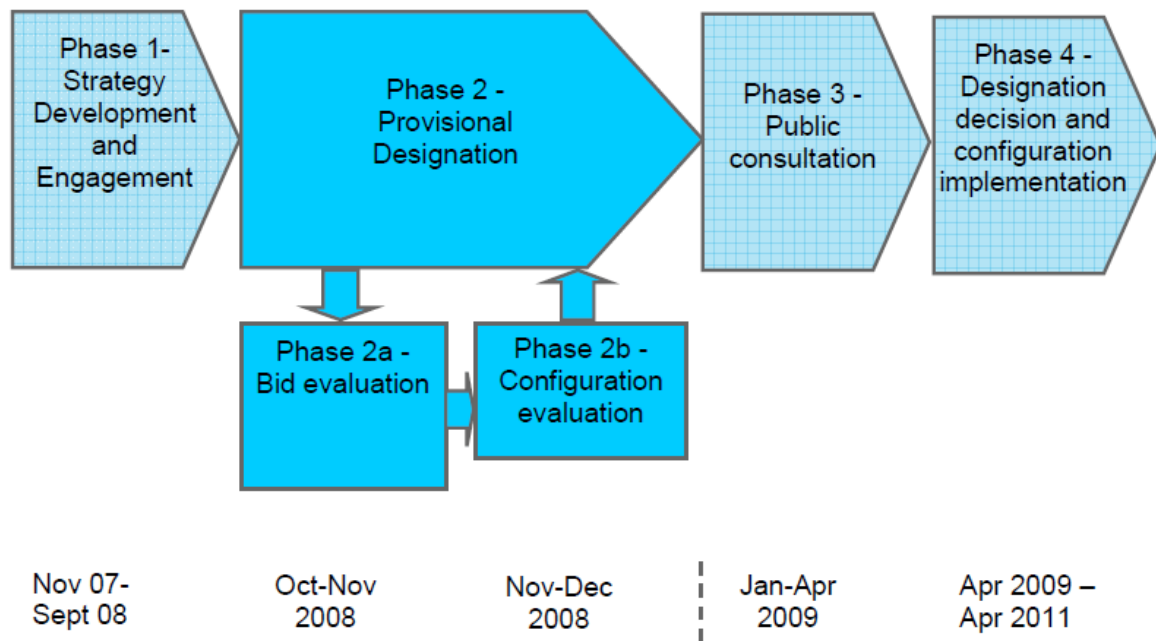
‘Londoners should be no more than 30 minutes travel from a [Hyper Acute Stroke Unit] HASU. On arrival a stroke patient should be assessed by a specialist, and have a CT scan and thrombolytic drugs (if appropriate), all within 30 minutes... once stabilised, patients should be moved from a HASU to a [Stroke Unit] SU to receive high quality stroke rehabilitation care.’ (NHS London, 2008b)

The document further discussed issues related to strategic management, including extending the role of clinical stroke networks to coordinate and regulate the continuing improvement of stroke care performance. The networks would be responsible for liaising with PCT commissioners, service providers and users and provide clinical leadership to encompass responsibility for innovation, audit, education and training and quality (NHS London, 2008b, p44). The remaining key conclusions from the report were that an additional £23m per annum was needed from London’s PCTs to fund the proposed improvements in acute care. Workforce numbers would have to increase and In-patient and community rehabilitation would also need to be improved (NHS London, 2008b).

These changes were not to take place within a vacuum. Health care for London called for stroke care reform alongside that of Major Trauma Centre reconfiguration. From January to May 2009, Health care for London conducted a public consultation exercise suggesting that

London ought to have 3 or 4 major Trauma units and 8 HASUs (NHS London, 2008c). The changes would mean that the London Ambulance Service (LAS) would have to improve its performance with respect to the identification and diagnosis of stroke and take patients to the Emergency Department of a hospital with an HASU, even if this was further away than a more local hospital without an HASU. This reflected work previously done in relation to cardiac care by the LAS. In theory, anyone suffering a stroke must be within 30 minutes of an HASU by ambulance – this had implications for the locations of HASUs especially given that the majority of stroke patients tend to be elderly and also tend to live on the outskirts of town (NHS London, 2008b). The consultation document suggested that 130 HASU beds would be required in London (in 8 HASUs) and 550 SU beds are needed (in 24 SUs). The new services would require an additional 570 whole time equivalent (WTE) nurses, 200 WTE AHPs and 16 WTE consultants and junior doctors (NHS London, 2008c). The consultation process generated just under 11,000 responses (NHS London, 2011a). The JCPCT met in July 2009 and agreed to recommendations made by NHS London for both the Trauma and Stroke centre reconfigurations with respect to both models and selected sites (NHS London, 2009b). The process is presented below in Figure 1 (NHS London, 2008b):

Figure 1: Reconfiguration Process (NHS London, 2008b)



This thesis concerns itself with the role of evidence across the whole reconfiguration and subsequent implementation process.

1.4 Reflection and motivation

It is important that research is conducted in a reflexive and critical way (Steier 1991; Alvesson and Skoldberg, 2000; Bowling, 2009) which is open about and accounts for the background, interests and motivations of the researcher. This is done briefly, below.

I commenced this part-time PhD study in September 2009 at the same time as I started in the Management Department at King's College London as a full-time Research Associate in Social Science working on a European Union (EU) FP7 funded research project aimed at measuring how evidence based stroke care was implemented into practice in different

European countries. The project was entitled the European Implementation Score (EIS) project and I worked on the project for four years – until September 2013. It was a collaborative project involving nine distinct work package teams composed of stroke clinicians, epidemiologists, health economists and qualitative social scientists from across numerous universities, governmental bodies and research institutes across the EU. I worked as a Research Associate in Social Science on Work Package 3 of the project under the supervision of both my PhD supervisors. Work on the project involved extensive literature reviewing and personally conducting over 130 qualitative interviews as part of a series of five case studies with stroke care professionals, managers and policy makers across three different EU countries as the lead researcher in the field. These qualitative interviews focused on the experiences of informants in accessing, interpreting and implementing evidence based stroke care at the macro-, meso- and micro-levels and included community, hospital and specialist care settings. The project yielded a number of publications by our specific work package focused on the implementation of evidence based health care in general (Boaz et al, 2011) and evidence based stroke care in particular (Baeza et al, 2012a; 2012b).

The EIS project with its stroke care focus led me to become immersed in a world of stroke research over these years. It also meant that I established professional relationships with many national and international stroke care practitioners and researchers. Many of the London based individuals involved in the EIS project were also involved in the London stroke services reconfiguration, leading to many informal discussions and also formal interviews as part of the data collection for this thesis. My links with these individuals were advantageous in securing interviews with both them and getting contacts for to interview other informants. However where my connections with these individuals may have been known by other observation subjects and informants, this may have influenced the ways in

they perceived me and hence impacted upon their words (in interviews) and actions (in observations). This is something I have reflected on whilst introducing myself before interviews and observations, and when analysing data.

The EIS Research Associate role kindled an interest in stroke care for me. Alongside this I have a long standing interest in evidence based policy and practice – specifically related to health policy which I had developed as a part-time MA Public Policy student at King's College London (2006-08). This is aligned with my professional background as a full-time administrator and manager in the NHS (2002-09). This professional and academic experience sheds some light on my initial interest in the research question. I was always conscious of the need to keep the PhD and EIS work separate (and have been helped in this regard by my supervisors), nevertheless, there were points at which the two projects have functioned in complimentary ways – for example thanks to the shared focus on stroke care and access to the micro-level London case study site which is used for data collection for the present thesis – whilst at others they conflicted – for example when EIS data collection necessitated extensive work abroad or when project specific timelines on occasion hampered my PhD focus. Whilst the analysis of data from the EIS case studies was collaboratively performed with other team members, data collected and used for this thesis was analysed individually by me – reflecting the distinct foci of the two projects. Appendix E includes a timeline highlighting the key commitments of the PhD and EIS work from September 2009-September 2014.

1.5 Summary

This chapter has introduced the main research question which the thesis will explore. It has justified the need for the research and placed it within the context of other related work whilst detailing the background and outline of the stroke care reforms in London. The following chapter (II) will review a number of relevant streams of literature detailing the strengths and weaknesses of these and where this present study may extend empirical and theoretical knowledge. Chapter III will then focus in greater depth upon the theoretical approach that the research will follow, discussing the concept of governmentality (Foucault, 2007), an analytics of government (Dean, 2010) and a review of contemporary health care management studies drawing on governmentality approaches. Chapter IV will present and justify the selected methodology behind the research with reference to the philosophical underpinnings, research design and research strategy and data analysis of the data extracted from case study interviews, documentary analysis and non-participant observations.

The empirical findings are presented in chapters V, VI and VII structured around the initial ‘problematisation’ of stroke care in London, then the design of the ‘solution’ to this, and finally the implementation of the ‘London model’ of stroke care delivery. Chapter VIII, the discussion chapter reflects on the findings and their theoretical significance for management studies knowledge. Chapter IX offers a short set of concluding thoughts around the thesis as a whole.

Chapter II

Literature Review

2.1 Introduction

This chapter seeks to critically review the ways in which evidence based health care (EBHC) has been characterised and interpreted across a set of key academic literatures. The chapter explores how clinical knowledge is constructed, legitimated and mobilised to influence health care policy making and management and how different professional, managerial and political stakeholders interact in reforming health care delivery. The rationale behind the literature reviewed in this chapter reflects an interest in how both macro-level Discourse and micro-level discourse (Alvesson and Kärreman, 2000) develop and impact upon stakeholders involved in shaping specific health services.

The chapter therefore begins with a discussion of the macro-level context of health policy making in England since the 1980s and how the concept of EBHC sits within the New Public Management (NPM) and post-NPM paradigms. This literature is important in contextualising the links between public policy and public management and how this has developed over the past thirty years. Following this, there is a focus on the impacts that ‘standardisation’ – which it is argued is central to the EBHC movement - has had upon the medical and allied professions, in both epistemic and management terms. This literature is important in demonstrating how social scientists have interpreted the sociological and management

impacts of attempts to reframe medical care delivery since the mid-1990s. Next the chapter considers how policy makers and social scientists have increasingly interpreted EBHC as a problem of ‘implementation’. This focuses analysis at the micro-level and explores the competing powers of ‘standardisation’ and ‘enactment’ of EBHC for health care professionals and managers. The penultimate section discusses the literature dedicated to health care merger and reconfiguration studies and how EBHC has been interpreted within these. The chapter then concludes by reflecting upon the theoretical and empirical state of these various literature streams and lays the foundations for the theoretical framework chapter which follows.

Before commencing the literature review, there follows a brief discussion of the methods used to locate the literature cited below. The first point to stress is the iterative and long term nature of how the literature review was conducted. This reflects the interpretive nature of inquiry at the heart of this work. As the research design and subsequent data analysis developed, an interest in Public Policy and Management literatures as well as Organisational Studies and Medical Sociology, and Sociology of the Professions and Implementation/Knowledge Transfer literatures emerged as significant. An interest in Foucauldian analysis of EBHC developed towards the end of the first year of this PhD study influenced by authors drawing Foucault’s ideas to explore changing regimes of governance in policy terms (Power, 1999; Newman, 2001) and in health care specifically (Waring, 2007; Pickard, 2010; Ferlie et al, 2011). These authors were identified mainly through ‘snowballing’ (Greenhalgh et al, 2008) and hand searches following references from significant papers and recommendations from colleagues. In addition, there were more formal searching strategies employed – for example via ASSIA and Social Science Abstracts – focused on ensuring that the health care merger literature for example was adequately

accounted for – likewise, in the following chapter, a formal search for health care management papers which employ a governmentality framework was performed. Finally, where appropriate comprehensive reviews were drawn upon – for example, the Spurgeon (2010) SDO report into reconfigurations, and the Greenhalgh et al (2004) Diffusion of Innovations work were both relevant to the present thesis.

2.2 The context of health policy making in the UK: New Public Management, Post-New Public Management and the rise of EBHC

A concern for the wider political and policy context which mandates and legitimates structural authority within the Public Sector and the NHS in particular is an integral element for deeper analysis of the importance of EBHC to health care policy making in recent years. Two important theories of Public Management emerging alongside the rise of EBHC are the New Public Management (NPM); and post-NPM theories of Network Governance (Ferlie and McGivern, 2014). The contribution of NPM and post-NPM theories will be critically discussed with a focus on the tension between demonstrable, population health care improvements based on *standardised* processes (Timmermans and Berg, 2003) and measured outcomes on the one hand, and the creation of ‘space’ for these to be negotiated locally drawing on the agency of professionals on the other (Davies and Nutley, 2000). It is suggested that this tension highlights the paradoxical political demands of conflicting timeframes and policy mandates within NHS management and policy making. In this context the epistemic and technical impacts of delivering EBHC have been of central importance since the mid-1990s.

Hood (1991) links the rise of NPM with four administrative ‘megatrends’ which see a shift from traditional bureaucratic public administration delivery: (1) attempts to reduce the growth of government spending and staffing levels (2) moves towards ‘privatisation’ of state assets and roles (3) the development of ‘automaton’ linked to IT advances and (4) an internationalised management agenda. These trends were identified in a key US text by Osborne and Gaebler (1992) who stress the importance of government – but call for a *new form* of government, that should be more effective and less bureaucratic – they seek to replace bureaucracy with ‘entrepreneurial government’ which builds on consumer choice and reflects the ‘knowledge-based economy’ of an ‘information society.’ Government, they suggest, should ‘steer, rather than row’ and they call for ‘less government and more governance’ (Osborne and Gaebler, 1992; p34). A concern for governing as ‘governance’ reflects the understanding that in modern liberal societies, concepts of knowledge, power and agency are complex, and dispersed rather than concentrated upon a single dominant (state or bureaucratic) actor (Fazekas, 2011). Whilst there are defenders of bureaucracy to be found in the Organisational Studies and Public Policy literatures – notably Du Gay (2005) and Self and Peacock (1993); economic critiques of bureaucracy (Niskanen, 1971; Tullock, 1987) have been increasingly influential from the 1970s onwards in setting a political context which is hostile to the allegedly self-interested behaviour of public officials and belief in the inevitability of government failure exploited by the Reagan administration in the US and Thatcher governments in the UK through the 1980s.

Hood (1995) outlines 7 key themes of the NPM: (1) moves towards greater ‘disaggregation’ of public sector organisations with separate budgets and identities (2) instilling more competition within the public sector and outwards towards private sector organisations (3) the importation of private sector management techniques to the public sector (4) cost cutting

initiatives and budget restraint within the public sector (5) more visible, active and ‘hands on’ hierarchical management within the public sector (6) more emphasis on explicit performance measurement against standards both ‘vertically’ and ‘laterally’ (7) increased control through output measures – such as payment linked to agreed performance metrics. Different countries implemented various elements of these themes to contrasting extents due to a multiplicity of factors; however, the UK is recognised as an early and extensive adopter (Pollitt and Bouckeaert, 2004). Furthermore within the UK, it has been claimed that the NHS was particularly heavily influenced by the NPM following the Griffiths Reforms and the introduction of General Management to the NHS in the 1980s (Ferlie et al, 1996; Ferlie and McGivern, 2014).

Ferlie et al (1996), drawing on empirical work focused on the UK health sector, state that the aims of NPM are contested, but themes of financial efficiency and a belief in the values of the market, increased managerial presence, and rhetorical commitments to decentralization and the primacy of the patient may be discerned. They argue that increased competition and management encroachment challenged medical professional dominance and historical forms of co-ordination. Rather than viewing this in simple terms of a loss of clinical autonomy throughout the profession, the authors suggest the picture was more complex – with ‘some winners, some losers’ and that a hybrid clinical managerial class emerged (medical directors, clinical directors). These individuals were well placed to manage clinical colleagues because the hybrid managers possess the technical knowledge to judge the competence of their peers (c.f. Mintzberg, 1983). Overall, this is a story of ‘adaptation’ according to their analysis. Professional powers have extended in some ways; clinical directorates and hybrid managers being examples of this. They have reduced in other ways; standardisation and systemisation of health care and published patient rights, an increase in audit and clinical governance.

However, crucially, clinicians have kept control of this aspect of regulation (Broom et al, 2009).

Noordegraaf and Abma (2003) emphasise how the New Public Management accentuates the practice of measurement and attempts to reduce ambiguity and complexity in policy making and delivery. They term this 'management by measurement' (MBM). The use of rational staged measurement cycles by practitioners theoretically aims to add to the transparency and effectiveness of administrative systems. Measured performance is compared with intended performance (Noordegraaf and Abma, 2003; p858). However, the authors suggest that this cycle rests on often untenable assumptions, and link this to ambiguity: 'when issues are ambiguous, interpretive spaces exist; when interpretive spaces exist, strict measurement cycles do not work because required conditions and assumptions cannot be met.' They suggest action occurs within 'interpretive spaces' so that management comes to be concerned with simplifying complexity (Noordegraaf and Abma, 2003; p861). Nevertheless reality is more complex and messy than such measurement systems can account for (March and Olsen, 1989; Weick, 1995) – resulting in organisational ambiguity (Parsons, 2002). They draw on the work of Brown and Duguid (1991) highlighting that measurement cycles linked to rationalist concepts of 'knowability', 'identifiability' and 'comparability' struggle for coherence in the face of organisational complexity and epistemic contestability (Noordegraaf and Abma, 2003; p869).

The centrality of measurement and audit to late twentieth and early twenty-first century policy makers is a key concern for Power (1999) who makes a number of important conceptual points in relation to the interplay between governance, management and auditing

principles and the ways these increasingly impact upon our understanding of collective and individual identities within organisational life (p42). Drawing upon neo-Foucauldian thought he links the growth of value for money (VFM) auditing techniques being applied to the public sector with NPM and the neoliberal agenda of indirect control and surveillance of subjects and organisations (p43) built on a false assumption about the ‘neutrality’ and effectiveness of auditable performance measures. This impacts upon intra-organisational control (Power, 1999; p52). He makes an important distinction related to how audit may be interpreted by practitioners as either ‘decoupled’ from, or ‘colonizing’ of performance and suggests this is a key area of interest in relation to clinical and medical audit – with implications for how we analyse the monitoring regimes introduced as part of EBHC. This has parallels with Berwick’s (1998) important distinction between ‘measurement for judgement’ in health care which focuses on guiding patients and commissioners with respect to clinicians’ and providers’ competences and ‘measurement for improvement’ which focuses on health care professionals themselves measuring and learning from and about their own practice (Timmermans and Berg, 2003; p206).

Dunleavy et al (2006) proclaim the NPM to be dead, and argue that numerous (but not all) aspects of the three key components of NPM (in ‘leading edge’ countries); ‘disaggregation’, ‘competition’ and ‘incentivisation’ have increasingly been whole or partly reversed or stalled in recent years – often due to symbolic alignment with policy mistakes or disasters (Dunleavy et al, 2006; p471) linked to the ways in which NPM policies increased institutional and policy complexity for policy makers and managers. They suggest there is a shift towards ‘Digital Era Governance’ (DEG) partly as an attempt to correct the anomalies of NPM policies and also in response to wide ranging and game changing advances in IT which impact upon government, public service delivery and citizens. In contrast to the three key components of

NPM, they offer three major components of DEG; reintegration, needs-based holism, and digitization processes. They cite for example, Blair's calls for 'joined up government' as an example of the reintegration component.

Dent (2005) likewise questions if policy making has entered a Post-NPM epoch. He compares the influence of NPM in the UK, Germany and Italy, suggesting that the move to post-NPM marks a shift from a managerial to a governance Discourse (neither precluding elements of marketization). Dent claims that New Labour moved the NPM agenda on from markets to increased oversight and regulation – setting good performers free, for example via the granting of Foundation Trust status. This is 'governance rather than government'. Dent cites Hood in calling this 'enforced self-regulation' and compares it to Courpasson's (2000) theory of 'soft bureaucracy.' Exworthy et al (1999) caution against the idea that NHS management styles may be viewed as linear shifts – from bureaucracy (1948-1979) to markets (1979-1997) to networks (from 1997). Rather, the three organisational methods have often coexisted, in different places and times. This is a logical approach – the stages model fails to 'recognise the political and organisational complexities of the NHS' and that 'multiple organisational forms' exist concurrently, spatially and temporally. For example, professionalised networks may be said to have been influential during the bureaucratic phase (as evidenced by Alford's (albeit New York) study of 1975). A useful suggestion offered by Exworthy is that networks may be more advanced for certain services. This seems a potentially fruitful way in which to picture the role of networks, as we might see from cancer, cardiac and now stroke services – they may be employed to improve outcomes in specific disease areas. They may be favoured because traditional, hierarchical localised methods at improvement have failed, markets are inadequate, and the specialised knowledge held by clinicians is seen as key to improvement. Networks offer a good way to incentivise clinical

leaders to reorganise and implement improved pathways and practices (Exworthy et al, 1999).

Lowndes and Skelcher (1998) caution that: ‘crude periodization of modes of governance can also carry with it the myth of progress – bureaucracy as all bad, markets as a necessary evil, and networks as the “new Jerusalem”’ (Lowndes and Skelcher, 1998; p331). They suggest such a narrative implies the reluctance of Public Sector managers to work to marketised ideals, thus preferring the collective ideals of the network model. They argue that such an approach fails to critically explore how power relations are affected in the new context of networks and ‘partnership’ work. They suggest critical analysis requires analysts to distinguish between organisational structure and modes of governance. ‘Partnership’ as an organisational structure is, in this critique, distinct from ‘network’ as a mode of governance – furthermore, ‘partnerships’ are associated with a multitude of forms of social co-ordination: which may include network, hierarchy and market. (p314). Different modes of governance are needed to tackle complex, ‘wicked’ or ‘messy’ policy problems in the disaggregated world of purchasers, providers following the NPM reforms of the 1980s and 1990s leading to distributed agency and fragmented communities of practice (p315). The authors insightfully argue that different modes of governance are apparent at different stages of policy making and delivery – thus we need a more nuanced understanding of how power and interaction fluctuates in networks and partnerships – sometimes competition will be key to interaction whilst at other points collaboration will be the central organising mode.

Rhodes (1997; 2007) has written extensively on the influence of policy networks in UK policy making following the effects of the NPM reforms of the Conservative administrations

of the 1980s and 1990s. The term ‘policy network’ refers to ‘sets of formal and informal institutional linkages between governmental and other actors structured around shared interests in public policy making and implementation’ (p1244). Multiple organisations here are interdependent upon each other to achieve policy goals. They have existed in UK policy making for a very long time – but he argues that the Thatcherite reforms of the 1980s led to a bureaucratic fragmentation which required increased network working paradoxically, whilst ‘governance refers to governing with and through networks’ (p1246) reflecting the weakened positive role of the state in the light of bureaucratic reform. Osborne (2006) has described New Public Governance (NPG) drawing on the power of networks and an increased ethos of trust to coordinate public management delivery – highlighting a more reflexive policy making process. It is in this period that the National Institute of Health Research and NICE emerge as significant players in the new establishment of more distributed loci of decision making and power. This highlights that evidence may become more important for policy making in an era where ideology is less so.

Pollitt (2013) applies a narrative analytic approach to review a key Public Service Reform White Paper of the early Blair government: ‘*Modernizing Government*’ (1997). In contrast to the rhetoric often displayed by previous Thatcher and Major Administrations, ‘*Modernizing Government*’ contains a commitment to ‘value’ rather than ‘denigrate’ public service and servants. Although the White Paper asserts that the ‘old’ arguments over more or less government were over (Pollitt, 2013; p910) – and therefore issues of Public Administration now are not political, but managerial, he suggests this is simplistic – in reality, different stakeholders involved in New Labour policy delivery frequently had different, conflicting aims and, over the course of the New Labour years: ‘modern performance measurement

systems would turn into a vast, highly centralized and deeply intrusive industry run from No.10 Downing Street and the Treasury' (Pollitt, 2013; p911).

The governance arrangements of the New Labour years are complex and contradictory. Other scholars have focused on the interaction between the language, policy goals, governing styles and theoretical approach of the Blair governments to governance. For example Newman (2001) uses discourse analysis to critique the approach of the early years of the New Labour government with respect to governance. She places the New Labour reforms in the context of the Thatcherite NPM movement and endeavours to extend understanding of how government policy at a macro-level can be dovetailed with micro-level trends for managers and professionals. Whilst the model of network governance would suggest that increasingly decentralised, networked organisational forms came to dominate policy – Newman posits that 'command and control' was simultaneously an important factor in New Labour governing – most strongly felt in the tightening of control over 'recalcitrant' professionals in health, education and social services amongst others and a 'partial softening of market imperatives' (Newman, 2001, p165)

She argues that New Labour continued the NPM trend of devolving power to public sector organisations and their managers – sometimes with coercive means of regulating activity: for example by overtaking 'failing' institutions. Other approaches however, allowed New Labour to 'govern at a distance' (Dean, 2010): through an expansion of audit and inspection, an increase of standards, protocols and quality measures, and incentive based funding regimes (Newman, 2001; p168). Newman questions whether these changes represent state power being withdrawn or extended. Increased partnerships and public involvement in decision

making could be seen to shift towards co or self-governance– this might be seen as ‘empowerment of individuals, communities and organisations’. Alternatively; ‘Post-structuralist theory however, would view [these ‘partnerships’] not in terms of empowerment, but as an enlargement of the range and penetration of state power.’ So although ‘direct’ state control may have been reduced – the state could be seen to have extended its reach so that arguably control might have been *increased* (Newman, 2001; p169)

Newman extends this analysis of disaggregated policy making in liberal society and its effects upon institutions and public sector workers across networks with an application of Foucauldian and ‘governmentality’ influenced thought drawing on the work of Rose (1996). The following chapter (III) offers a full explanation of the key aspects Foucault’s governmentality work and the technical implications of specific terms and how language is utilised to express particular ideas. It is necessary here however to indicate that governmentality as a concept is concerned with the ‘art of government’ and how in liberal societies, specific ‘practices’, or ‘tactics’ of government seek to govern individuals’ actions through harnessing their freedom and influencing ‘mentalities’ of rule (Dean, 2010). As will be explained in the next chapter, this leads the analyst to become increasingly concerned with concepts such as *freedom, agency, language, subjectivity* and *control*. Newman explores these concepts within the ‘discursive practices of “modernizing” governments’ (Newman, 2005; p718). It is through this that meanings are generated via ‘small, everyday acts.’ She suggests that within the ‘micro-politics of state modernisation’ *transgression* is limited as a subject position (Newman, 2005; p730). Newman highlights the ways in which micro-level interactions are central to the enactment of macro-level policy goals – this is the key locus for research into implementation and standardisation, however concepts of leadership, agency and freedom become increasingly contested (O’Reilly and Reed, 2010; Martin and

Learmonth, 2012) leading to Critical, Postmodernist and Foucauldian approaches to analysis to provide enriched understandings of the shift ‘to indirect governance’ (Ferlie and McGivern, 2014).

In further work, co-authored with Clarke (Newman and Clarke, 2009) Newman once more draws on Foucauldian theory to explore conceptions of publics, politics and power with an interest in paradox, ‘visibilities’ and ‘assemblages’ which point to a concern for epistemic and technical aspects of policy making and a concern for the ways these are shaped by and come to shape the identities of those working in and/or touched by new conceptions of ‘publicness’ (Newman and Clarke, 2009; p15)

NPM supposedly shifts public sector organisations ‘down grid and down group’ by making them more like private sector organisations in their working practice and freer in designing and implementing local policy solutions in contrast to traditional public administration models (Dunleavy and Hood, 1994; p9). However, during the New Labour years the extent to which competition drove health policy is questionable (Mays and Dixon, 2011), and nationally standardised clinical targets became more high profile and culturally significant than ever. This illuminates some contradictory elements of NPM as an organising form. It has proven itself to be adaptable to various political agendas and types of critiques (Dunleavy and Hood, 1994), simultaneously and somewhat paradoxically however NPM reforms often adopted ‘one size fits all’ elements leading to aspects of ‘monoculture’ and ‘mimetic isomorphism’ (DiMaggio and Powell, 1991; Hood and Peters, 2004; p278).

Perhaps due to the politically high profile nature of NHS policy making (and the centrality of the NHS to the identity of both ‘old’ and New Labour), state based funding, and resolute power bases of professional groups essential to effective delivery, the competitive diversity at the heart of the entrepreneurial state model cited by Osborne and Gaebler (1992) struggled to impose itself fully in the NHS context. Further factors include the ways in which clinical staff adapted to take on management roles – for example as clinical directors (Fitzgerald and Ferlie, 2000); and also the maintained control of clinical audit systems by the medical profession (Herk et al, 2001). There are a number of problems with the wider NPM literature as represented by authors such as Hood, Pollitt and Dunleavy when applied to empirical projects within a specific sector such as health. Firstly, these authors operate at an abstract level, developing ideal typologies to account for generalised change across disparate sectors and an eye to international comparisons. This fails to account for sectoral and national issues linked to long term political trends within administrative systems, and also fails to explicate the gap between political reality and rhetoric. For example, New Labour claimed to be committed to ‘devolving power’ and making government more responsive, collective and open (Pollitt, 2013):

‘However, this does not mean that the centre has given up control – it is dispersal, but not a fragmentation. In so far as “partnership” becomes a reality rather than just a rhetoric, it entails a new form of control that crucially involves language – shaping the culture, discourse and language of the dispersed agents of government rather than directly controlling what they do.’ (Fairclough, 2000; p5)

The conceptual fusion of *government with 'rational thought'* (Foucault, 2007; Dean, 2010) is analytically useful in the study of the application of EBHC values to English health policy making. On one hand there is an appeal to (macro-level) Discourse to 'change cultures' but on the other hand this is acknowledged as being centrally related to change that has been internalised through local (micro-level) culture in which the discourse is constitutive of the values of EBHC (Alvesson and Kärreman, 2000). The governmental role is to encourage certain preferred conduct(s) to become 'instinctive' (Dopson and Fitzgerald, 2005):

'EBHC is not, however, simply about getting specific pieces of research evidence into practice. It is about creating a culture where practitioners automatically think in an 'evidence'-based way every time they see a new case, where it becomes instinctive to seek out research evidence and base treatment decisions on that evidence' (Dopson and Fitzgerald, 2005; p37)

A key idea here is that 'techniques of control work best when they make individuals "want" what the system needs in order to perform' (Thornborrow and Brown, 2009; p370). Co-option of clinical leaders into senior policy making positions enhances the epistemological legitimacy of 'evidence based' health policy making (Armstrong, 2002); but crucially, the agency of professional staff must be harnessed to implement the new government policies in health care. Post-NPM theories such as those advanced by Newman (2001; 2005), Newman and Clarke (2009) and Ferlie and McGivern (2014) are theoretically useful. These authors draw on illuminating concepts around the dispersal of power and agency in contemporary society. Along with Power (1999) these authors highlight the utility of taking a detailed interest in the work of Foucault and in particular ideas which emerge from his writings on

Governmentality (Foucault, 2007, Dean, 2010) when thinking about how modern liberal government functions for scholars of public sector management.

Having focused on the macro-level policy context and pointed towards potentially illuminative critiques which may extend theoretical understanding of the impact of EBHC on modern health care, the next section defines the key elements of EBHC with reference to how these impact upon professional knowledge and workforce relations.

2.3 The impacts of standardisation on medical professionals

A central concern of EBHC is *standardisation* – the attempt to ensure that all medical professionals adhere to validated common principles and knowledge bases when treating patients – such a concern has political implications both within and beyond the profession (Timmermans and Berg, 2003). Following this assertion there are two key corollaries. Firstly, EBHC poses epistemological challenges to the traditional modes of medical decision making (Carr-Hill, 1995; Schon and Stanley, 2003) , and secondly, this in turn impacts upon the power structures and systems of control within the medical profession and how it interacts with governmental, lay, academic and commercial stakeholders (Armstrong, 2002; Lambert, 2006). Recent years have seen a proliferation of institutions and agencies both clinical (such as the Royal Colleges in the UK) and governmental (such as NICE in the UK and AHRQ in the USA) and new international academic journals committed to the promotion of evidence based practice and systems of thought which emphasise the conscious efforts to frame EBM as a social movement aimed at increasing the scientific basis of clinical decision making within medicine and beyond – to nursing and AHP groups (Berkwits, 1998; Timmermans and Berg, 2003 p18).

Early proponents of EBM suggested it would represent a ‘paradigm shift’ in health care conceptualisation and organising (Guyatt, 1991) in its early years and whilst fellow originators of the concept of EBM have subsequently come to question the ‘paradigm shift’ terminology (Haynes, 2002) and other critics reject the premise that it represents a revolutionary discontinuity with what went before (Sehon and Stanley, 2003), the subject has generated significant debate both within the medical profession and amongst medical sociologists. Carr-Hill (1995) argues that the efforts at ‘universalising’ knowledge production and interpretation - central to EBM ignores the complexity central to the evaluation of evidence type, implementation and disparate views over the correct role for judgement in decision making (Greenhalgh and Wieringa, 2011). Goldenberg (2006) goes further and suggests there is an intellectually coercive element to EBM which affects both practitioners and the public. She challenges the apparent unproblematic nature of evidence underpinning EBM and argues that ‘the appeal to the authority of evidence that characterises evidence based practice does not increase objectivity but rather obscures the subjective elements that inescapably enter all forms of human enquiry’ (Goldenberg, 2006; p2621). Therefore we ought to be sceptical of claims which portray EBM as ‘politically disinterested or merely scientific’. Attempts to standardise medical knowledge - in terms of understanding what a disease or treatment is or are, and the protocols needed to construct a valid knowledge base to treat patients and measure the effectiveness of the interventions may fruitfully be seen as a political process. Much of the time - especially with relation to strategic level change - the evidence may be partial, contested and rely upon ‘expert consensus’ (Klein, 2000; Nutley and Davies, 2000). Such evidence is necessarily subjective. Guideline development which takes place amongst experts seeking common consensus is not necessarily conducted in transparent fora, but rather represents a political process reflecting the balance of the views of expert

contributors; “the fact that a group of individuals think that a practice is beneficial does not ensure that it actually is” (Woolf et al, 1996, p947; Timmermans and Berg, 2003 p4).

Lambert et al (2006) suggest that ‘EBM constitutes a profound challenge to the ways in which established health care professions, such as biomedicine impart knowledge to new members and maintain professional autonomy’ (p2614). Central to this is the ability of the profession to respond to increased pressure to provide standardised care which is linked to policy concerns around rationalisation and regulation.’ Critics and supporters agree that standards emerge out of political concerns and can be used to implement or thwart regulation. But they disagree on the need for such regulation and the usefulness of standards as policy tools’ (Timmermans and Berg, 2003; p20). This leads to a discussion around the second key concern of this section – how EBM has impacted upon the power dynamics and issues of control of the medical and allied professions.

Issues of power, control and the autonomy of the medical profession need to be seen in their historical context. Freidson’s (1970) original model of Professional Dominance became highly influential in the conceptualisation of organisational and political relations in health care (Abbott, 1988; Wolinsky, 1988; Light, 1991). This medical dominance necessitated administrative and managerial reforms to introduce a more balanced relationship between the medical profession on the one hand and patients, other AHPs and management on the other (Freidson, 1970, p176). Light (1991) characterises this tussle in terms of ‘countervailing powers’. Transparency of medical processes and standardisation were part of this process which changed the dynamic nature of state-professional relations (Freidson, 1988). Abbott (1988) argues that ‘the development of the formal attributes of a profession is bound up with

the pursuit of jurisdictions and the besting of rival professions' (p30). This is a useful perspective as it opens up the possibility of studying both dominant and subordinate professional groupings and how they interact in a more sophisticated way than traditional professional dominance models. Since the early 1970s, Professional Dominance – as a classic sociological paradigm for characterising medicine's relations with capital and the state - came under increasing strain (Haug, 1973; Wolinsky; 1988; Harrison and Ahmad, 2000; Salter, 2002).

Freidson's later work laments these changes which have assaulted the 'credibility of the professional ideology' (2001, p197). He links the proliferation of standards and protocols with broader economic and political trends which lead to a re-stratification of the medical profession. This, he posits may empower non-professional general managers to control the work of professionals in new ways. Armstrong (2002) follows Freidson in suggesting that a clinical administrative elite 'often grouped around the academy and professional colleges' increasingly comes to control the work of individual practitioners through protocols and guidelines. This leads to a paradoxical situation where 'freedom' for the profession as a whole from non-professional governmental intrusion is secured by increased 'control' of individual practice from the professional centre (Armstrong, 2002, p1772). Others have noted how EBM 'solidifies hierarchical relationships' between consultants and juniors (Timmermans and Angell, 2001; Broom et al, 2009). EBHC therefore may be seen to impact upon the traditional autonomy enjoyed by professional groups. A very useful distinction here can be made between firstly; *Professional autonomy*: 'the regulation of the profession as a whole by controlling entrance to the field, self-monitoring, developing a body of specialized knowledge and running professional organizations' and secondly; *Clinical autonomy*: 'the

control the individual practitioner has over routine work activities and decisions, the freedom to be innovative in the work process' (Timmermans and Berg, 2003; p84).

Moreover, these subtly distinct types of autonomy may fluctuate dynamically and be influenced by jurisdictional battles (Abbott, 1988) between established professions which create clinical practice guidelines in order to reduce clinical uncertainty in worlds awash with masses of information emphasising in turn the 'deductive' quality of clinical autonomy rather than its traditional 'inductive' nature. In contrast, emerging professions more often use clinical practice guidelines 'to claim a special status and to solicit jurisdiction over a technical domain' and make visible that which was previously unappreciated or hidden (Timmermans and Berg, 2003; p90).

The Professions literature does contain a North American bias and draws upon ideal type, macro-level generalisations in a number of instances which do not hold in countries like England with fully tax funded health services. However, it is an important literature stream for scholars of health care policy and management as it does highlight that professionals *are* different in how they organise themselves (and compete with others) from non-professionals. Having introduced a number of key concepts focused on how the medical sociology and sociology of the professions academic literatures have problematised the fluctuating nature of professional power and how it may have been influenced by first the EBM and more latterly the EBHC movements, the following section will focus on how policy makers, managers, clinical leaders and policy analysts have framed the rise of EBHC.

2.4 Evidence based health care as a problem of implementation

It is suggested in this section that EBHC has been framed by public policy makers, managers, clinical leaders and policy analysts as a problem of *implementation*. This is significant, as it demonstrates that EBHC is clearly deeply embedded in to clinical, policy and management communities – the question has become not *whether* to implement evidence based regimes of practice, but rather *how*. Dopson and Fitzgerald and colleagues (2005) produced an important text in which they focus on the ‘implementation gap’ which an interest in the EBM movement has elucidated for social science researchers. Their focus is less on standardization – i.e. the processes by which clinical practice is debated and changed, and more on how those new standards are translated into practice, or knowledge is ‘enacted’. This frames the problem in public policy and managerial terms. They are also keen to focus on the multi-professional dimension of EBHC rather than just EBM and the messiness of competing ‘jurisdictions’ (Abbott, 1988) of heterogeneous health care organisations. The authors locate their study in the New Labour period here as they point towards the linkages between EBHC and evidence based policy. This is important as many critiques of EBHC fail to make this conceptual indication. They link the evidence based policy movement politically to the “‘modernizing” government agenda’ that ‘have confirmed the central role that evidence is expected to play in policy making for the twenty-first century.’ (p28). This link is central to understanding the macro-level, or outer context which shapes how EBHC is conceptualised and interpreted during the New Labour period and the role of evidence in the reconfiguration of stroke services in London from 2007. The *modernization agenda* is a central concern of authors such as Power (1999), Fairclough, (2000), Newman (2001; 2005), Newman and Clarke (2009), and (Pollitt, 2013).

In the English context, NPM principles and techniques of increased (quasi)markets, management and measurement were closely aligned with the values of the New Right through the 1980s and 1990s. Hence the election of the New Labour government in 1997 and Frank Dobson as its first Health Secretary in a generation with a pledge to save the NHS from Conservative party cuts and threatened privatisation appeared to herald a new, more consensual, less combative era. Blair's third way was self-consciously post-ideological and (it was claimed it would be) based on evidence based policy making. Stoker (1999) for example has argued that evidence has increasingly been employed as an antidote to fill the vacuum left by the decline of traditional left-right ideology and politics of conviction. Evidence based policy making sits uneasily with NPM (Hood and Peters, 2004), but clearly has parallels with EBM and EBHC.

In health care as Davies, Nutley and Smith (2000) suggest, at a micro-level (i.e. bedside) EBM has proven more successful than at meso- (i.e. strategic planning) or macro-levels (i.e. national policy making). There are practical as well as theoretical and ideological reasons for this. Firstly, the collation and subsequent dominance of RCT data, in which trials can be performed in the biomedical arena and applied at the bedside, cannot be replicated with regard to meso-, or macro-level structural reforms. This would be impractical and inhibited by cost. Large scale policy change and service reconfiguration is problematic to trial. Klein (2000) suggests that the two main reasons for the difficulty in moving from EBM to evidence based policy making are firstly; the concept of evidence itself is problematic – just as the dominance of the hierarchical model of evidence is open to question in EBM, so too, how evidence is ranked in evidence based policy making is no simple matter. Secondly, Klein

suggests that a simple corollary between EBM and evidence based policy making fails to appreciate fully the complexities of the policy process.

In this new political context, EBHC empowers and legitimates managers and policy makers to take a greater interest in how to change professional practice in the NHS because knowledge and decision making is increasing codified and open to the scrutiny of managers and policy makers in pushing an 'improvement agenda'. A key technical aspect relates to the powerful new Information Technology advances from the 1980s and the 'informating organization' (Zuboff, 1988). Halladay and Bero (2000) suggest three different factors which impede attempts at bringing about wide ranging change in the NHS – these are cultural, logistical and contextual. They argue that culturally, NHS professionals traditionally displayed suspicion towards commercial Quality Improvement methods – this is linked to dislike of the internal market reforms of the Conservative administration of the 1990s, they also point to professional boundaries which inhibit knowledge sharing and professional-managerial clashes over jurisdiction. Logistical challenges include poor information systems, sharing and skills and a lack of time to dedicate to systems change. Contextual factors include the role of social networks, different learning styles across and within different institutions and the role of patients in the uptake of research. Nutley and Davies (2000) emphasise the 'different worlds' inhabited by policy makers and practitioners and the problems of communication between these 'different worlds'. Drawing on Rogers' diffusion of innovation model (1995), they point to the distinction between centralised and decentralised diffusion systems. The advantages of the former include central quality control over the policies and innovations to be diffused, but a centralised approach may encounter resistance from practitioners. The advantages of the latter are that practitioners tend to prefer having the ability to shape their own practices which in turn promotes a 'closer fit' between innovation

local context and actual problems; whilst the disadvantages include lack of central oversight and also the potential for ineffective innovations to be diffused. This tension between centralised and decentralised modes of implementation and how these interplay with efforts at *standardisation* is a key factor in the literature. They also point to the ontological challenges of evidence based practice and the disagreements between those approaching the issues from post-modernist and positivist positions.

It was argued earlier in this thesis that EBM fostered a ‘movement’ of adherents and collected critics within the medical profession. Likewise, the new disciplines of ‘implementation studies’ and ‘knowledge translation’ emerged from the mid-1990s in academic circles with scholars from diverse social science, management, clinical and epidemiological traditions bringing conflicting views, theories and ontological assumptions as funding for research around implementation increased via government agencies keen to learn about ‘what works’ and learn how to secure health services which are both efficient and effective.

Early proponents of EBM are criticised for possessing simplistic and positivistic assumptions leading to passive strategies to get research into practice (Dopson and Fitzgerald, 2005). Competing researchers with an interest in the implementation of EBHC draw on different and contradictory theories about organisational change. The debate over the role of theory becomes central to the epistemological positioning of implementation and knowledge transfer studies. Graham et al (2006) lament the confusion around the competing concepts of ‘knowledge translation’, ‘transfer’ and ‘exchange’, as well as ‘research utilization’, ‘implementation’, ‘diffusion’ and ‘dissemination’. They emphasise the social nature of

knowledge translation and the dynamic and complex interaction processes between the various stages and present a cyclical model for implementation. They stress the importance of a shared understanding around the language used to express the distinct stages of the process they identify. Ward et al (2009) performed a narrative review of the knowledge transfer literature and identified 28 different ‘implementation’ models – the vast majority of which had been produced since the mid-late 1990s. They noted that most of these models remained untested empirically, so it is difficult to evaluate their respective utility. They did however identify five common components of the knowledge transfer process: (1) Problem identification and communication; (2) Knowledge/research development and selection; (3) Analysis of context; (4) Knowledge transfer activities or interventions; (5) Knowledge/research utilization. In addition, thematic analysis suggested the components might be arranged into one of three separate knowledge transfer processes; linear, cyclical and dynamic/multidirectional. Cyclical models were found to be most frequent (p162).

Eccles et al (2005; p111) highlight the debate between and amongst the community of Health Service Researchers and clinical epidemiologists around the recognition of the failure of ‘implementation’ research as an a-contextual, non-theoretical disciplinary concern. Their primary contention is that implementation is first and foremost a ‘science’, and that theory should be employed systematically to in time ‘raise’ implementation research to the level of ‘other clinical sciences.’ This suggests certain types of ‘scientific’ theories may be more attractive to these authors than other more ‘interpretive based’ theoretical formulations. Interestingly, much qualitative health care management research (including implementation studies), at least in British Management Study circles has rejected this positivistic step and has increasingly moved in a ‘symbolic interpretive’ direction (Dopson and Fitzgerald, 2005). However, much of the funding for Health Service Research comes from government funding

bodies which tends to reflect a more positivistic ethos. As funding for health policy research becomes closely linked with normative implementation studies – it influences the acceptable approaches which researchers may take to evaluation. This is an important aspect of the rhetorical power of the evidence based movement overall – it is very difficult for researchers to be critical of it whilst remaining credible – it is of course hard to challenge its inherent virtue. Learmonth (2003) employs a Critical Management Studies (CMS) framework to suggest that the majority of qualitative studies focused on NHS management fail to critically examine the underlying managerial assumptions – there is a clear danger that implementation studies all too often fall into this trap also.

In an important paper Greenhalgh and Wieringa (2011), following Learmonth (2003) and Crilly et al (2010), suggest that CMS approaches might be useful to unpick the complexities of knowledge/power relationships in health care decision making – how does ‘best evidence’ become so? And what are the roles played by ‘hierarchies of evidence’ in shaping understanding around what clinicians ought to do? They suggest researchers critically study the influence of ‘ the pharmaceutical industry, medical device manufacturers, commercial software companies, management consultants, research leaders and political and third sector lobbyists in defining what counts as research knowledge and mobilising resources to generate and distribute it’ (Greenhalgh and Wieringa, 2011; p508). Moreover, they call for more research on the development of guidelines at the strategic level and also ‘knowledge interaction’ – focused on how different types of knowledge come together and influence policy making and macro-level decision making. The role of EBHC regimes of knowledge at the strategic level of decision making in health care management and policy focused on the construction of guidelines and practice protocols to be implemented (not to mention the

active roles of ‘research leaders’) are under-researched topics to which this thesis aims to contribute.

Having critically noted the normative elements of some ‘implementation’ research, it is worth now highlighting that much useful work has been produced in recent years with an emphasis on the *contextual* factors at the heart of implementation issues. This is important as it highlights the importance of micro-level discursive and relational practice (Weick, 1995; Brown and Duguid, 1991; Fairhurst, 2008; Pye, 2005) and the role of professional agency (Dopson and Fitzgerald, 2005; Currie et al, 2010; Lockett et al, 2012) in changing practice. Greenhalgh et al (2004) produced a review of the literature which asks how innovations in health service delivery and organisation might be firstly spread, and secondly, sustained. They distinguish between diffusion – passive spread of ideas; dissemination – targeted and planned action aimed at significant stakeholders to encourage uptake of an innovation; implementation – the active attempt to embed an innovation within an organisation; and finally sustainability – the ‘routinization’ of an innovation (Greenhalgh et al, 2004, p582).

The comprehensiveness of the study is clearly very useful; however, a criticism might be that there is little discussion of broader public policy concerns and the influence of macro-level policy contexts in impacting upon diffusion of innovations in general terms. A further criticism, as noted elsewhere by Boaz et al (2011) is that there can sometimes be a lack of criticality in questioning the validity of evidence behind various innovations – the focus tends to be the success of the implementation abstracted from wider impacts of change mechanisms (these concerns are however recognised and discussed by Greenhalgh and Wieringa in the 2011 paper discussed above). Nevertheless a great strength of the Greenhalgh et al (2004)

study lies in the recognition of the importance of context in dissemination and hence the problems associated with universalistic models of translation (Greenhalgh et al, 2004, p615). This clearly however presents a problem for studies aimed at achieving external validity and ‘objective’ comparison of studies (Pawson et al, 2005). The authors emphasise (amongst other recommendations) that further research should be theory driven and focused on process of change rather than ‘package’ orientated. The centrality of context as a concern of implementation and knowledge exchange processes is also emphasised by Contandriopoulos et al (2010) who suggest that in implementation studies, or knowledge exchange processes for both organisations and policy, the starting point should be an analysis of the context which will in turn influence the choice of policy implementation tools rather than the other way round. Three important dimensions of context are identified – the first is political and questions the polarising effects of the proposed policy; the second is economic – and questions how the costs of the proposed policy will be shared amongst stakeholders; the third is social and relates to the institutional structures and methods of communication. This is of high relevance to studies of reconfiguration with their strong political and economic implications for policy.

A further central concern of the implementation literature linked to the importance of context is that practitioners need space in which to develop their own locally specific models of delivery if they are likely to be successful – but this finding may then clash with (national/regional) attempts at practice standardisation. Ferlie and Dopson (2005) highlight that rather than focus on knowledge itself, we should look at the communities of practice and the different agendas which different (health care professional) groups pursue and be cognizant of the ‘jurisdictions’ they endeavour to protect as they ‘enact’ evidence in particular work settings (Ferlie and Dopson, 2005). These processes are clearly likely

to be messy and complicated and distinctive in ways not accounted for by classic rational models (Van de Ven, 1992; Ferlie and Dopson, 2005). Brown and Duguid (1991) draw on an empirical ethnographic (non-health care based) study to demonstrate the disjunction between the ways in which employees actually perform their work tasks and the ways in which such work is described by workplace manuals, guides and job descriptions. They suggest that innovation and organisational learning occurs within informal and often unregulated ‘communities of practice’ separate from the official picture of organisational life derived from institutional documentation. They make a very useful distinction between *canonical* and *non-canonical* practice within organisations. They suggest that in an effort to simplify and codify work practices, management frequently come to expect workers to perform tasks based on an idealised set of criteria which may not bear much resemblance to the reality of the performance of tasks which require tacit knowledge and skills not accounted for in organisational level directives. This is *canonical practice*. In practice, workers learn how to perform their tasks through doing their everyday work, and they come to understand the unstated complexities of their tasks in this way. In doing so workers diverge from *canonical practice* and engage in *non-canonical practice*; they learn informally from other (more experienced) colleagues and come to practice in ways which work, but which often bear little resemblance to the official protocols drawn up to guide their work.

There are three key elements which are central to these processes: narration, collaboration and social construction (Brown and Duguid, 1991). Problems are conceptualised and tackled through discursive practice and knowledge is located within these discussions amongst staff. The shared nature of these narratives highlights the collaborative nature of these processes – leading workers to socially construct views of their work and the nature of the problems they

face in doing that work. This in turn may influence their ‘identity work’ which takes place in both the performance of work practices and the story telling which accompanies it. Learning takes place by way of ‘legitimate peripheral participation’ (Lave and Wenger, 1991) ‘learners are acquiring not explicit, formal “expert knowledge”, but the embodied ability to behave as community members’ (Brown and Duguid, 1991; p48). They conclude: ‘to understand the way information is constructed and travels within an organisation, it is first necessary to understand the different communities that are formed within it and the distribution of power within them.’ (Brown and Duguid, 1991; p55)

Likewise Gkeredakis et al (2011) combine theoretical and empirical insight to locate evidence *in practice* if knowledge translation is to be successful. The authors argue that the competing perspectives on the knowledge-practice gap (evidence based management and co-production perspectives) both place too much emphasis on knowledge itself, rather than how it is used in practice. They suggest that management practice is socially complex and that evidence and knowledge must be *instrumentalised* (Tsoukas and Vladimirou, 2001) and to be used as a tool. They emphasise policy implementation should be seen as an iterative process with multiple ‘feedback loops’ and suggest also that well-crafted narratives are important in making the case for implementation and rendering the complexities of implementation more understandable. Davies and Nutley (2000) draw on the work of Argyris and Schon (1978; 1996), and Senge (1994) and place the need for organisational learning within the politicised context of long term NHS reforms. They suggest the New Labour Quality Improvement agenda necessitates improved organisational learning capabilities but are also cognizant of the difficulties inherent in achieving such a goal. They distinguish between single loop learning (detection and correction of error) and double loop learning (radical, locally led innovations and service redesign) and lament that the latter is difficult to establish whilst the

competing organisational pressures of NHS delivery take precedence – unless prompted by some kind of ‘crisis’ (Davies and Nutley, 2000; p999). They point to the impact of ‘problem based’ learning in medical schools and EBM which equip practitioners with ‘skills rather than a reservoir of facts’ (Sackett et al, 1996; 1997). The authors suggest that the pressures of National Service Frameworks and the audit regimes they sit within may prompt single loop learning but inhibit double loop learning (in contrast, other New Labour policy documents with a longer-term focus such as ‘*A first class service*’ (1998) may offer more hope of the double loop learning systems needed to embed cultural change which will last) (Davies and Nutley, 2000; p1000).

This insight is instructive. The kind of ‘learning systems’ and reflective practice needed to embed long term cultural change based on evidence based principles which enable ‘unlearning’ of poor practice requires long term, localised, collective approaches to organisational change managed upwards, whilst concurrently cognizant of local contextual conditions (Davies and Nutley, 2000). Because the implementation of EBHC change is contextually dependent, as suggested by these authors, then policy needs to leave space for contextually accommodating factors to interplay with broader policy mandates.

Standardisation is a double edged sword – there is an existential tension between the centre and the periphery. Greenhalgh et al (2009) follow Berg’s (2001) assertion that the question of success in implementation is ‘socially negotiated’: ‘if a team sets out to achieve X but along the way learns things or encounters challenges that convince it that Y is a more appropriate (or practicable) goal, then it will have “succeeded” if it achieves something approaching Y’ (p410). This challenges positivistic modes of evaluation of implementation processes and emphasises a constructivist understanding of localised learning – policy

makers and strategic management must leave ‘space’ for local negotiating of meaning within local contexts – this may however have negative impacts upon drives for ‘standardisation’.

This chapter has so far highlighted the theoretically rich public policy, management, OS and medical sociology literatures which scholars have drawn upon to analyse the impact of EBHC. This thesis explores the role of assumptions over clinical evidence and how this may frame strategic-level reconfiguration of an urban stroke service. Therefore it is necessary to review the literature focused reconfiguration and mergers in health care. It is noted below that this literature stream tends to be less rich in theoretical terms than some of the broader literatures discussed thus far. Potential reasons for this are discussed below.

2.5 The ‘politics’ of reconfiguration and mergers in health care

There are few studies which explore health care reconfigurations empirically in the acute sector (Fulop et al, 2012). In addition to this, definitional issues and differentiated analytic approaches that hamper comparisons across the studies which do exist. There are also two key conceptual issues which hinder the health care reconfiguration and merger literature. Firstly, many studies take a highly normative approach which questions whether organisational change is ‘successful’ or not, this in turn means that many of these studies are insufficiently critical in theoretical terms. Secondly, many studies fail to question the nature of evidence and knowledge behind reconfigurations and the power coalitions which construct these knowledge bases. Nonetheless a number of important empirical findings can be drawn from this literature which usefully foregrounds this thesis.

Spurgeon et al (2010) produced a systematic review of the international literature relating to strategic health service delivery change and highlight the pluralist nature of the conflicting ‘political’ standpoints of clinicians, managers and members of the public (Spurgeon et al, 2010; p15). They conclude that it is useful to view reconfiguration as a process which takes time rather than as a singular event, and also that ‘politics’, conflict and the often irreconcilable goals of key players make satisfactory outcomes for all highly unlikely. Furthermore, they are sceptical about the role played by public consultation in health configuration (Spurgeon et al; p18).

The authors draw on the arguments of McKee and Healy (2002) to highlight how costs and a desire to control them have traditionally been seen as drivers towards service reconfigurations. Parallel to this the work of Ferguson et al (1997) is presented. This highlights the argument frequently emanating from the medical lobby that *larger is better*. The authors argue that a major rationale behind recent reconfigurations has been that outcomes in specialised units where more patients are treated by more highly specialised staff are superior to outcomes achieved in traditionally delivered less specialised units – as suggested by Farrington-Douglas and Brookes (2007). The evidence that bigger, specialised centres are better has a very high degree of contestability – a number of studies exist which show that high volume centres may have worse outcomes than ‘those with some slack’ (Spurgeon et al, 2010; p56). Local factors may be more important than the generalised concept that bigger, and more specialised units are universally, inherently superior vis a vis patient outcomes. Furthermore, the evidence is incomplete when guiding thresholds at which efficiency is achieved, and there is a danger in extrapolating findings from one clinical area

as being indicative of proposed performance in other areas. Likewise claims related to the changes in access and times taken in travel to care are disputed. The subject of the clinical labour market and its regulation forms another strand of ‘supply side’ arguments for reconfiguration (Spurgeon et al, 2010).

Central themes identified in this comprehensive review are (1) the plurality of conflicting view-points amongst the actors concerned – many committed to the status quo, others committed to change; (2) the role of perceived economic rationalisation – this is attractive to commissioners of services and resisted by practitioners and patient groups; (3) key arguments over the links between specialisation (e.g. larger is better), travel times, and labour market implications all draw upon *highly contestable evidence*. It is therefore a combination of local plurality of views drawing on non-definitive evidence amongst a context of economic suspicion which *politicises* reconfigurations so starkly. However, a criticism might be that is little attempt made to go further and unpack why and how the evidence base behind reconfigurations is so contested – for example, how is the evidence constructed, and by whom, at what point and to what ends? (Greenhalgh and Wieringa, 2011) How are services constructed as ‘failing’ or problematic? To what extent are such issues linked to ‘causal stories’ in which problems are (re)-constructed as amenable to human action (Stone 1989) in certain times and places? And finally, how are such ‘political’ issues shaped by and shaping of the identities of key players with respect to their conflicting view-points?

The following studies of mergers and reconfigurations of provider services in the health care sector provide empirically significant themes which underline the ‘political’ controversies identified by Spurgeon et al (2010). Ahgren (2008) examined the merger of a Swedish

hospital from two existing hospitals in 1996. The ostensible motivation for the merger was that ‘bigger hospitals lead to lower average costs and improved clinical outcomes’. The study consisted of both qualitative and quantitative elements and concluded that it is not necessarily ‘better to be big’ and that a great degree of turbulence was caused for the employees – and was still present a decade post-merger. Turbulence caused by forced merger is a recurrent theme in this literature, picked up by Cortvriend (2004) who looks at the effects of merger and demerger in an English PCT again focusing on employee perceptions of forced change. A distinction in this study is made between those clinical areas which are ‘cherry-picked’ for special treatment, and how employees here may experience increases in motivation, compared to the de-motivational aspect of working in a service area not singled out for increased financial or organisational focus.

Mercer (2008) in another non-UK study emphasises the challenge of implementing change in the face of staff resistance. The study emphasises the importance of having clear united leadership in the face of limited evidence behind the effectiveness of the merger. Leadership and organisational culture clashes emerge as key themes in work by Fulop et al (2005) which focused on four in depth case studies 2-3 years post-merger. This highlights the key roles played by context, complexity and process manifested in ‘perceived differences in organisational culture’ and fears of ‘takeover’ by one organisation and values over another. The concept of ‘stated and unstated drivers’ behind the merger process is useful. Stated drivers included: internal management cost savings, safeguarding specialist units and guaranteeing service developments, ensuring the quality and level of service in light of external policy drivers, improve conditions and career prospects for staff and address recruitment and retention problems. Unstated drivers included: addressing managerial deficits, addressing financial deficits, local and national political context (in this case

pertaining to the status of one of the hospitals involved). The study notes that the notions behind the mergers were often based on ‘simplistic notions of organisational change’ which failed to factor in the human effects that such change would have on staff and also that there was ‘little evidence that the economic and clinical objectives that formed the drivers for mergers are achievable’ (Fulop et al, 2005; p129) .

Hutchings et al (2003) suggest that the role of outside management consultants employed to reduce management costs as part of service reconfiguration actually *increase* costs; at least in the short to medium term. The politically sensitive context of hospital reconfiguration is emphasised by Brown (2003) focusing on the Kidderminster General Hospital case which reached its apogee in the 2001 general election. The paper highlights the contextual factors in which prospective reforms, closures or ‘downsizings’ take place and the importance of localism, symbolism, and ‘sense of place’ in relation to whether plans are supported or challenged by local communities. The economic context in which reforms are proposed is crucial – in the case of Kidderminster, ‘severe financial difficulties’ were behind the review. In a similar vein Parkinson (2003) places the proposed plans to reconfigure acute services in Leicester at the turn of the century, and the public reaction to these in a Habermasian framework to highlight the complex and competing claims of democracy, legitimacy, EBM and public attachment to certain services being delivered in certain sites regardless of the ‘expert’ view.

Choi and Brommels (2009) provide a focus on pre-merger decisions rather than post-merger contexts (which much other merger/reconfiguration literature examines). The long term forces driving merger include economic efficiency and research excellence, but the

importance of short term economic crises in putting the (unpopular in many circles) merger formally on the table as an idea to be pursued in reality is emphasised. This long term retrospective view allows the authors to show the role of local and economic contexts in delivering or denying large scale change, and creating the ‘window of opportunity’ which allowed the merger to take place when it did (Choi and Brommels, 2009; p251). They question whether there must be a ‘crisis’ in order to fundamentally change the decision logic of political organisations.

Cameron et al (2007) study the reconfiguration of stroke services in Ontario, with a focus on the role of evidence in promoting these changes. While this paper is useful given its explicit focus on the role of evidence, the definition of evidence is narrow and the paper is based on a rather normative view of the implementation process. They suggest that clinical evidence is used by clinical decision makers, and economists respond to economic evidence, but the authors rather uncritically accept this, so we learn little of the tensions inherent in the development and implementation of the stroke system and the epistemological role of forms evidence and the communities who construct and control these. An empirical finding of note in this study is the difficulty in implementing change in rehabilitation, long term and community care (Cameron et al, 2007; p9) which is a recognised problem in stroke care (Baeza et al, 2012a).

Oborn (2008) in an example of a reconfiguration study offering theoretical insights, points to the socially constructed frameworks of legitimacy used by different groups to make sense of service change using the Kidderminster saga to differentiate between ‘moral legitimacy’ and ‘cognitive legitimacy’ in the views of competing factions in contentious change. Oborn

suggests that there are a number of 'irrational' processes that are central to reconfigurations. (Oborn, 2008; p11) She explores the role of discourse to highlight how conflicting rhetorical strategies were used by the competing factions and how they tended to argue past each other. The 'pro-change' lobby appealed to the Discourse of medical science whilst the counter 'anti-change lobby' were 'expressed in moral terms, de-legitimizing the changes as partisan;' favouring the medical establishment view at the expense of local views on wellbeing. '[A]t a fundamental level, "specialists" are constructed by interlocking discourses which privilege and maintain their positions of decision-making within their domain.' Thus the political value of change and evidence is highlighted thereby illuminating how and why different groups rationalise policy objectives (Oborn, 2008; p17).

Whether represented by service reconfiguration or provider merger, organisational change in health care is an inherently 'political' process in which evidence is just one of many elements (Spurgeon et al, 2010). Different factions; patient/public, clinical, managerial and political may use conflicting values and frameworks to interpret the utility of proposed changes (Alford, 1975; Denis et al, 2001). Different contexts may be more or less 'receptive' to change (Pettigrew et al, 1992). The clinical and managerial rationale behind reconfigurations and mergers, often based on potential patient outcome improvements and economic efficiencies is contested throughout the reviewed literature. There are both stated and unstated drivers behind proposed changes (Fulop, 2004). There is very little focus on the epistemological rationale behind service reconfigurations and the use of 'evidence based' Discourse. The transitional power dynamics as negotiated between policy makers, managers and different clinicians in the production of new 'standardising' protocols is not critically explored. The existing reconfiguration literature fails to explore service change with reference to public management theories of NPM and governance regimes. Therefore, despite

its empirical usefulness, this particular literature stream fails to increase theoretical knowledge around professional and managerial power, control, knowledge and identity conflicts relating to mergers and service change more broadly (Addicott and Ferlie, 2007). Dean (2010) argues that it is at precisely such times as whole scale reorganisation and change that these issues are ripe for critical analysis.

2.6 Summary: EBHC, policy, management and service reconfiguration

The role of EBHC as a locus to examine the shifting epistemic values of policy makers, managers and professionals is potentially fruitful because EBHC opens a window on the ways in which knowledge is constructed and codified as well as both the ‘top down’ and ‘bottom up’ approaches to its implementation (Timmermans and Berg, 2003; Ferlie et al, 2011). Public policy making and public management in the New Labour era was based on a number of paradoxical assertions and conflicting issues of governance (Newman, 2001; 2005). ‘Hard’ NPM tools based on increased measurement and interventionist management regimes sat alongside post-NPM ‘network governance’ (Rhodes, 2007; Pollitt, 2013) levers based on collaboration and the kind of ‘learning systems’ and reflective practice needed to embed long term cultural change based on evidence based principles cognizant of local contextual conditions (Davies and Nutley, 2000).

Whilst there is a large literature focused on how the epistemic impacts of EBHC have changed relationships within the medical profession and with state actors at a macro-level; and of the challenges which policy makers and managers face in implementing EBHC policies, an important gap in the literature is a lack of understanding about how (both clinical

hybrid and non-clinical) managers – particularly at the strategic level interpret and use the discourse of EBHC in their interactions with senior clinicians and research leaders to achieve (what may be messy) local, regional and national policy goals. This is especially so with reference to service reconfigurations which have ‘politically’ polarising effects and for which the evidence itself is very much contested (Spurgeon et al, 2010) but which have been hitherto under-researched in theoretical terms. Recent studies focused on reconfigurations and health service mergers suggested that this literature frequently fails to build on many of the established literature streams reviewed above and (with notable exceptions) tends to be theoretically weak. Therefore there is scope in the literature for a theoretically driven study of large scale reconfiguration which focuses on the ways in which EBHC changes professional and managerial perceptions of valid evidence in service reconfiguration and also draws on wider concepts from the management and public policy traditions.

A second area with scope for development is around the ways in which ‘actionable knowledge’ (Dopson and Fitzgerald, 2005) – in the form of ‘evidence based’ protocols impacts upon different managerial and professional groups within an organisation. In particular, building on work by Newman (2001; 2005); Ferlie et al (2011; 2013) and Ferlie and McGivern (2014) this thesis aims to develop theory by drawing on the work of Foucault and scholars with an interest in governmentality (Miller and Rose, 2003; Foucault, 2007; Dean, 2010) and focusing on how this may aid understanding in the disputed NPM and post-NPM policy terrain in NHS management regimes of the late New Labour years.

Chapter III

Theoretical Framework

3.1 Introduction

Increasing numbers of authors have turned to the work of Foucault in recent times searching for more sophisticated ways of interpreting the interplay of politics, power, governance and changing conceptions of the state in contemporary society (Burchell et al, 1991; Power, 1999; Rose, 1999; Newman, 2001; 2005; Miller and Rose, 2008; Dean, 2010). Others have used his work specifically to focus on management and organizations (Townley, 1993; McKinlay and Starkey, 1998) and public administration (Bogason, 2005). Of most relevance for this thesis, is the development of governmentality scholarship in health care organisation and service delivery over the past decade (Doolin, 2004; Flynn, 2004; Sheaff et al, 2004; Waring, 2007; Ferlie et al, 2011; Martin et al, 2013).

As described in the previous chapter, exposure to the work of these authors during the early stages of the PhD research highlighted that a Foucauldian framing might be apposite for a theoretically additive thesis focused on the role of evidence in influencing the reconfiguration of stroke services in London. This decision was deductively guided by a desire to explore the ways in which knowledge creation and discursive techniques of power may influence the development and implementation of evidence based regimes of practice (Dean, 2010) across

a specific biopolitical (Foucault, 2007) terrain. Other theoretical framings might have been chosen – for example, Addicott and Ferlie (2007) have discussed the utility of pluralist (Dahl, 1957) and structuralist (Alford, 1975) approaches to power in organisational research in the NHS – however, post-structuralist approaches (Fairclough, 1992; Newman, 2001) appeared particularly fruitful for furthering understanding around the construction and implementation of evidence, and evidence based practice.

This chapter will begin by introducing key aspects of Foucault's (2007) work on governmentality and how these may be applied to contemporary health care policy making and management. A particular aim is to ground these theoretical constructs in contemporary debates around evidence based stroke care to emphasise the practical utility of this approach. Then the chapter will introduce an 'analytics of government' (Dean, 2010) as a framework to be used in this thesis to apply a governmentality approach to the analysis of the London stroke service reconfiguration. Following this the chapter will thematically review the governmentality influenced literature focused on health care policy and management which has developed since the 1990s and draw out a number of key foci and questions which may be usefully explored with respect to the empirical data presented later in the thesis.

3.2 Governmentality

One of the advantages a governmentality approach is its historical sweep and concomitant interest in both macro- and micro-level features of how societies and individuals come to

function. Thus, when analysing how stroke care in London has been problematised and approaches to remedy this are designed; different governmental aspects can be examined. Essentially, it is possible to simultaneously view long term historical factors behind the growth and establishment of certain powerful groups and modes of knowledge, and also frame methods of understanding which relate to how this might influence the management and behaviour of individuals and how they function on a day to day level. Foucault taught a course at the *College de France* from 1977-78 where he developed and articulated his ideas relating to what governmentality might mean. Foucault suggests that for him, this word “governmentality” means three things:

‘First, by “governmentality” I understand the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has the population as its target, political economy as its major form of knowledge, and apparatuses of security as its essential technical instrument. Second, by “governmentality” I understand the tendency, the line of force, that for a long time, and throughout the West, has constantly led towards the pre-eminence over all other types of power – sovereignty, discipline, and so on – of the type of power that we can call “government” and which has led to the development of a series of specific governmental apparatuses (*appareils*) on the one hand, [and, on the other] to the development of a series of knowledges (*savoirs*). Finally, by “governmentality” I think we should understand the process, or rather, the result of the process by which the state of justice of the Middle Ages became the administrative state in the fifteenth and sixteenth centuries and was gradually “governmentalized”’ (Foucault, 2007; p108)

Foucault emphasises that the state should not be viewed as an almighty, unified force, rather scholars should look at the ways in which government functions; how knowledge and power are created and directed via governmental channels and that rather than the state taking over society, a process of ‘governmentalization’ of the state has occurred (Foucault, 2007). This macro-level distinction has implications for how power functions at a micro-level. Dean (2010) cites the idea of government as ‘*conduct of conduct*’ pointing to the multiple meanings of the word *conduct* – firstly to lead, or to guide, perhaps in a calculated way he suggests. Secondly, conduct may be seen as a form of self-direction – how we conduct ourselves. Thirdly, we might conceive of the meaning of the word conduct when employed as a noun – i.e. behaviour, action (Dean, 2010; p17)

Government at a macro-level functions as a way of ordering society. Modern liberal democracies are seen to function in the interest of their populations, and legitimacy is derived from this. This creates a compact between those who are governed and those involved in the systems which govern. An example here would be the post-war welfare state, and, pertinent to this work – the NHS. In England, the health needs of the population are assured – funded by general taxation. Likewise, the police service is provided by the government to protect the population from certain forms of danger. Compulsory education up to the age of 16 is provided by the government. Social security payments are provided to those out of work. In a liberal democracy there are debates about the values or otherwise of different levels of economic interventionism. Neoliberal critiques problematise Keynesian welfarism, and supposedly promote more *laissez-faire* paradigms which emphasise market rationality,

choice, enterprise and responsible autonomy (Dean, 2010). However, even within a neoliberal position, there is a general acceptance of the necessity of some form of government function for the benefit of the population.

Government at a micro-level functions as a way of (self) ordering individuals. Part of the compact between those who are governed and those involved in the systems which govern is an understanding of what constitutes acceptable and unacceptable conduct at different times. Townley suggests governmentality can be understood as a ‘neologism derived from a combination of government and rationality’ (Townley, 1993; p520) – our values and conduct are shaped by a broader Discourse, the legitimacy and validity of which being derived from governmental apparatuses and ethical standpoints. We are free to function how we choose; however, we are constrained in our choices by the dominant Discourses of the regimes of practice in which we live – hence the significance of how we problematise ourselves in relation to dominant and countervailing forms of power (Foucault, 1986; Haugaard, 2002; p186).

There are multiple interpretations of Foucault’s work and how it may be applied to the question of structure and agency; these include some which suggest that he allows for an autonomous subject (Archer, 2000; Han, 2002), some who argue that when ‘composed’ Foucault will allow a role for agency, and when ‘excitable’ not; whilst consistently denying the existence of an autonomous subject (Bevir, 1999; 2004) – pointing towards a concept of ‘situated’ agency (Bevir, 2011). Power (2011) suggests that one of the most persistent criticisms of Foucault and his approach is a lack of a recognizable theory of action and role for agency at all. Others suggest that it is possible to infer different interpretations of

Foucault's work at different stages of his career, as his interests change over time from archaeology to genealogy (Dews, 1984). Foucault himself suggested towards the end of his life:

'Perhaps I've insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others, and in the technologies of individual domination, in the mode of action that an individual exercises upon himself by means of technologies of the self' (Foucault, 2000, p225)

Foucault's late work (as opposed to his middle period) concentrates on 'practices of freedom' as opposed to 'states of domination' (McKinlay and Starkey, 1998, p232; Foucault, 2000, p225). There is an implicit move from a focus on *marginalization* to *problematization* (Gutting, 2011). His earlier work demonstrated how marginalised members of society were confronted by and constructed via a power/knowledge nexus emphasising disciplinary power. This clearly left little room for the role of agency. However the later work does not focus on the marginalized; rather, *problematization* is Foucault's way of focusing on 'fundamental issues and choices confronting "mainline" (non-marginalised) members of a society' (Gutting, 2011). In these cases, individuals do have the resources for some kind of self-formation. McKinlay and Starkey (1998) term this process as a shift from *subjection* to *subjectification* - in that the self may transform itself and be a willing partner in the development and exercise of knowledge and power in some instances. There is a focus here on how 'technologies of the self' (McKinley and Starkey, 1998; Foucault, 2000) are applied by agents and how these change behaviour, status and performance.

Government then, can be understood both as an attempt to shape the conduct of others and that of ourselves. In liberal societies, government is inextricably linked with ideas of freedom – thus ‘counter-conducts’ or acts of resistance (Foucault, 2007; p202) are identifiable. The concept of governmentality can be used as a framework for understanding how the power at the macro-level (government) subtly functions at a micro-level whilst maintaining the idea of freedom throughout the various governmental systems. Having introduced some key aspects behind a conception of what governmentality may be understood to be, the next section turns to questions relating to how it functions with a focus on the development of EBHC.

Biopolitics and the power/knowledge nexus

The term ‘biopolitics’ expresses the governmental concept that human beings are viewed collectively as a species, and are governed as such, hence problems of how to regulate and improve conditions are rationalised on a population scale. Biopolitics is, for Foucault:

‘the endeavour, begun in the eighteenth century, to rationalize the problems presented to governmental practice by the phenomena characteristic of a group of living human beings constituted as a population: health, sanitation, birth-rate, longevity, race’
(Foucault, 2000; p73)

These concerns for governing at the level (and in the interest) of the population are related to conceptions of security and the state. Foucault demonstrates the historical evolution of the

concept of state control in the population's (health) interest with a three-stage example comparing how lepers in the Middle Ages were excluded from society, then how the Plague regulations imposed (disciplinary) quarantine measures on towns, whilst the Smallpox inoculation practices from the 18th Century drew upon novel forms of knowledge and calculation to manage the risk of disease in new ways (Foucault, 2007). These evolving examples demonstrate how the exercise of power and the centrality of a calculable population as a target of government became more sophisticated over time:

‘The elaboration of a notion of the population was a gradual process that was both technical and theoretical, relying on the development of statistics and census-taking, and the techniques of epidemiology and demography... Population is an absolutely key term in the elaboration of the art of government at the end of the eighteenth century. This is because it figures and binds together two different trajectories. On the one hand, it provides the “life-administering power” of bio-politics with an object. On the other, it provides liberalism as a critical rationality with a government-limiting critique’ (Dean, 2010; p128)

Biopolitical interventions are ‘linked to the phenomenon of the town itself’ (Foucault, 2007; p63) and the ‘most biopolitical of ends: [is] the maintenance of life and the wellbeing of the population’ (Dean, 2010; p142) making the study of the London stroke service reconfiguration apposite to theoretical development around the biopolitical theme. Whilst Ferlie et al (2011) suggest that evidence based guidelines leading to service reconfigurations might be a form of ‘biopower’ overall this is a neglected area in other studies found within Foucauldian literature in health care and management. Indeed a major theoretical contribution

this thesis makes to Foucauldian influenced health care management literature is to demonstrate the utility of interpreting service reconfigurations as biopolitical interventions (Foucault, 2007).

Foucault (2007) describes how biopolitical interventions may be seen as ‘practices of security’ which draw on four distinct notions; *case*, *risk*, *danger* and *crisis*. The ‘case’ here is not the individual (or patient) case – rather it is ‘a way of individualizing the collective phenomenon of the disease... in the form of quantification and of the rational and identifiable’ (Foucault, 2007; p60). Following this, if a disease can be interpreted both at the group and the individual level, then the ‘risk’ in terms of mortality and morbidity for different segments of the population can be calculated. Next the variability of risk highlights which sub-groups from within a given population are in most ‘danger’ of suffering from a given disease – Foucault points to the danger faced by the under-threes living in urban areas posed by smallpox (p61). The final notion is that of ‘crisis’ which in Foucault’s example is described as a ‘sudden worsening, acceleration, and increase of the disease’ (p61).

An understanding of ‘liberal’ rule is important here. Rose describes liberal rule as ‘government at a distance’ (Rose, 1999; p49). Dean (2010) defines liberalism as ‘the critique of excessive government’ (p267). This approach suggests government has become an ‘art’, divorced from the figure of the sovereign – governing in the interests of the population whilst simultaneously limiting its apparent remit which in turn secures its own legitimacy. This has implications for how society is structured and policed and how health, illness and medicine are conceived.

In the ‘Birth of the Clinic’ (Foucault, 1975), Foucault conveys the genealogy of medicine and its symbiotic relation with government power. Rose allies this process with what he terms the development ‘the social’ (and we might term the general population, or society) to document how the influence of government flowed through society carried by expert knowledge and professional bureaucracies (Rose, 1999; p133). Rose also highlights the role played by numbers and statistics in the production of ‘objective knowledge’ and the legitimacy this brings to both professional groups and government in order to create discourses and behaviour conducive to state interest. This special kind of expert knowledge is free from direct political control and market influences (Rose, 1999; p133). The following passage (though long) is highly pertinent with respect to the connection of numbers with expert authority:

‘When the authority of authority is secure, when authoritative judgements carry inherent authority, when the legitimacy of their authority is not subject to sceptical scrutiny and challenge, experts have little need of numbers. But where mistrust of authority flourishes, where experts are the targets of suspicion and their claims are greeted with scepticism by politicians, disputed by professional rivals, distrusted by public opinion, where decisions are contested and discretion is criticised, the allure of numbers increases. It is in these circumstances that professionals and experts try to justify their judgements on the ground of objectivity, and frequently frame this objectivity in numerical form. Numbers are resorted to in order to settle or diminish conflicts in a contested space of weak authority. And the “power of the single figure” is here a rhetorical technique for “black boxing” – that is to say, rendering invisible and hence incontestable – the complex array of judgements and decisions that go into

a measurement, a scale, a number. The apparent facticity of the figure obscures the complex technical work that is required to *produce* objectivity' (Rose, 1999, p208)

Recourse to scientism and faith in the power of numbers resonates with the methodology of the EBHC movement and is useful when evaluating how a governmentality framework might be applied to an attempt to account for its emergence. Mykhalovskiy and Weir (2004) suggest that traditionally two approaches have been used by social scientists to critique EBM - political economy and humanism - and that this is problematic. They suggest post-modernist approaches, and empirically based research as apposite to remedy the traditional failings of social science approaches to gaining a greater understanding of the implications of EBM. The application of a Foucauldian framework to the analysis of EBHC may potentially increase understanding of the power/knowledge relations both within the medical profession and between it and the government.

Biopolitics is useful when conceptualising the role of epidemiology and both its theoretical application *vis a vis* the EBHC movement, and more specifically the idea of reconfiguring local health services on a population (as opposed to a personal) level. Epidemiology and aggregated numerical knowledge of a systematic nature sits atop the hierarchy of evidence in EBHC (Davies, Nutley and Smith, 2000; Timmermans and Berg, 2003). Epidemiological knowledge has traditionally been created and interpreted by clinicians, public health experts, statisticians, health economists and other health service research specialists. This knowledge is interpreted by governments to direct specific programmes of health reform. These programmes then require further monitoring and evaluation of effectiveness, feeding back

further information, knowledge and evidence to shape policy. This may be seen as a kind of power/knowledge nexus (Ferlie and McGivern, 2014).

Surveillance and disciplinary power

Having discussed the concept of EBHC as a power/knowledge nexus, this section considers the Foucauldian concepts of surveillance and disciplinary power. This is most famously understood in relation to Foucault's work on Bentham's Panopticon (Foucault, 1977). Rose suggests that the dystopian visions of 24 hour surveillance society which some analysts have interpreted as being heralded by Panopticism miss the point that Foucault was making – the Foucauldian reality is rather more subtle:

'Panopticism did not model a dominating totalitarian society: it was a diagram of a mode of power that sought to induce a certain relation of human beings to themselves. Discipline... was not a means of producing terrorized slaves without privacy, but self-managing citizens capable of conducting themselves in freedom, shaping their newly acquired "private lives" according to norms of civility, and judging their conduct accordingly' (Rose, 1999; p244)

Disciplinary power coexists with governmental and sovereign forms of power (Dean, 2010) and can be seen as a 'productive force' (Hodgson, 2002; Brown and Lewis, 2011) highlighting the links between Foucauldian interpretations of power Elden (2002). EBHC represents an important shift in the governing of health care professionals (Timmermans and

Berg, 2003; Mykhalovskiy and Weir, 2004) and impacts upon subjective self-identity: ‘it is when we are called upon to change our relation to government that we are also required to change our relation to ourselves, to change our subjective self-identity, and it is then that we become aware of the ways in which the political power of the state impinges on our individual lives, that we *feel* it’ (Burchell, 1991; p145). This theoretical standpoint is important when we look at recently prevailing themes in health care management and regulation such as audit, clinical governance, national advisory bodies and regulators and network organisational trends. These are reform *programmes* (Dean, 2010) which seek to change clinician behaviour. It is worth exploring these ideas further in relation to stroke care in England, and its governance. As highlighted earlier in this work, there have been a whole host of publications produced in recent years at a macro level by various clinical and government bodies examining the structural weaknesses of current stroke provision and potential roadmaps to improvement; The Department of Health (DH) published a *National Service Framework for Older People* (2001) and *National Stroke Strategy* (2007). The RCP also published *National Clinical Guidelines for Stroke* (2004), as well as the joint guidelines published with NICE in 2008. The National Audit Office (NAO) has also produced two major documents focussing on quality and cost-effectiveness; *Reducing Brain Damage: faster access to better stroke care* (2005) and *Joining Forces to Deliver Improved Stroke Care* (2007). Fundamental also, is the RCP produced a bi-annual *National Sentinel Audit of Stroke for England Wales and Northern Ireland* which has been published since 1998. This includes data from all hospitals in the 3 nations which admit and treat stroke patients giving a comprehensive picture of the state of stroke care in the UK (excluding Scotland).

At a national level, guidelines prescribe best practice, thus the clinical autonomy enjoyed by previous generations of practitioners to choose methods of care outside of published accepted

best practice is reduced – knowledge created and validated at the epidemiological level trumps individual patho-physiological rationality as a widespread modality of practice. EBHC (theoretically) aims to regularise standard treatment across the profession (Timmermans and Berg, 2003). To relate back to the image of the panopticon, for the last sixteen years, the RCP has produced clinical audit reports which highlight the performance of every hospital in the country in relation to stroke – thus aspects of clinical performance are open (to varying degrees) to view – however, improvements have been slower in England than in other countries (Rudd, 2005).

Performance can be measured by national audit and local clinical governance. In a Foucauldian sense, self-governance might be seen to take place (more or less successfully) within this context at a micro-level. Such developments open up questions about how these new forms of governance impact upon clinical-managerial relations and broader issues around health care policy and management. These will be explored in this thesis through a specific analytic approach introduced below.

3.3 An analytics of government

Foucault's work offers not a 'global principle for analyzing society' (Foucault, 1978 – quoted in Burchell, 1991 p85) nor 'general theory' but rather a particular 'ethos' drawing on 'conceptual tools' to explore contemporary political questions (Rose, 1999; p5). A number of influential scholars clustered around Nikolas Rose and Peter Miller and termed 'London Governmentalists' (McKinlay and Taylor, 2014) have applied Foucault's thoughts on governmentality to contemporary social issues in highly innovative ways. Rather than a meta-

theoretical approach, Governmentalists use Foucault's ideas about neoliberal governance as a 'toolkit' to perform analysis around empirical or historical questions (McKinlay and Taylor, 2014; p15). In this vein, Miller and Rose (1992) propose a 'problematics of government' influenced by Foucault's work. The authors offer 'some elements of an "analytic" of problematics of government' (Miller and Rose, 1992; p175) and they illustrate these through an investigation of liberalism, welfarism, and neo-liberalism. Central concerns are apparatuses of government, technical means of idea translation, knowledge and the role of state agencies in government. They cite three differences between their approach and that of the traditional sociology of state formation; firstly, they reject a realist approach, emphasising instead an approach which focuses on how those in authority have approached power and methods of governance. Secondly, they emphasise the role of language, to gain an understanding of both the systems of thought and systems of action behind government action. Their final concern is that of knowledge – not just of ideas, but rather of theories, experiments and techniques – 'know-how' (Miller and Rose, 1992; p177).

They focus in turn upon, the programmes of government – emphasising that government is a '*problematizing*' activity (Miller and Rose, 1992; p181). This prompts consideration of which problems are made visible, and which kept hidden at different points in time. A discussion of the technologies of government, and the need to focus on the 'humble and mundane mechanisms by which authorities seek to instantiate government' (Miller and Rose, 1992; p183) is emphasised. The authors describe 'inscription and calculation as technologies of government' then 'expertise and government' with relation to the governmentalization of the state. Finally they provide a description of welfare provision in the UK and in particular of NHS management in the twentieth century within the context of the changing paradigms of welfarism and then neo-liberalism.

Dean (2010) builds on the work of the London Governmentalists to provide an indicative framework to apply governmentality influenced approach to questions of policy. He terms this perspective an ‘analytics of government.’ (Dean, 2010; p30) This approach focuses on how ‘regimes of practice’ come in to being and function – exploring questions of knowledge, authority and power. This offers the analyst a toolkit to take a ‘critical approach by transcending moral judgements about the proper form of “good” and “democratic” government’ (McKee, 2009; p471). This thesis will employ features of this ‘toolkit’ to explore the role of evidence in the reconfiguration of London stroke services. It is therefore important in this section to highlight the key elements and specific forms of terminology used in this approach and how they apply this thesis.

The first point to make is that an analytics of government aims not for ideal type generalisations but rather focuses on singularities of governing and conducting ourselves and others. It explores specific ‘regimes of practices’ and how they emerge, function and change over time:

‘[R]egimes of practices or regimes of government... involve practices for the production of truth and knowledge, comprise multiple forms of practical, technical and calculative rationality, and are subject to programmes for their reform. It is important to realize that regimes of practice exist within a milieu composed of mentalities of rule without being reducible to that milieu’(Dean, 2010; p28)

The term '*regimes of practices*' refers to ways that key social functions of government such as 'curing, caring, punishing, assisting, educating' are in effect done; within which, '*regimes of government*' represent a subset of these regimes of practices focused ways of directing 'the conduct of the self and others' so relate to human behaviour. '*Programmes*' are an 'aspect of governmental rationality. These are explicit, planned attempts to reform or transform regimes of practices by reorienting them to specific ends or investing them with particular purposes. Programmes often take the form of a link between theoretical knowledge and practical concerns and objectives' (Dean, 2010; p268).

An analytics of government challenges 'taken-for-granted' assumptions about the ways in which things are done. It encourages us to critically question why certain practices are normalised within for example a 'health system' and explore how and why the ideas behind these practices were introduced and prioritised over others. Different regimes of practices may compete and influence each other - for example, 'regimes of calculation drawn from accounting and auditing' (Miller and Rose, 1992; Power, 1999; Dean, 2010; p31) have been employed extensively in health and other public sector services to regulate practice and offer new forms of accountability which influence 'professional' practice in England over the past 25 years as part of NPM reforms – this was discussed in the previous chapter.

There is an interactive relationship between regimes of practices and different forms of knowledge - such as medicine - over time. The symbiosis between knowledge and regimes of practices is important in conceptualising how 'programmes' of reform to challenge regimes of practices are established: 'the practices of curing, punishing and so on, are invested with multiple programmes that employ certain types of knowledge to reform or radically challenge

their operation, to reorient them to new goals and objectives and act upon the desires, aspirations, needs and attributes of the agents within them' (Dean, 2010; p32). This is useful for furthering understanding around how knowledge and evidence impact upon regimes of practice and government in health care.

An analytics of government commences then by studying how programmes of reform *problematise* or question the ways in which things have traditionally been done. For this present study, the programme would be the attempts to reform stroke care in England since the mid-1990s and more specifically the attempts made by the London SHA from about 2007 to question the effectiveness of the delivery of stroke services in London and the subsequent work to design and implement a new strategy for delivering stroke care in the capital. This will in turn influence the regimes of government (the shaping of the conduct of health care staff involved in stroke care) employed to change aspects of the regimes of practice involved in the caring of stroke patients.

However, Dean suggests that there is an intrinsic logic or *strategy* to regimes of practices that cannot be reduced to specific programmes for reform – rather, a key element of an analytics of government is to highlight the 'disjunction between the explicit, calculated and programmatic rationality and the non-subjective intentionality that can be constructed through analysis' of *how* regimes of practices function and influence behaviour (Dean, 2010; p32). We need to differentiate between the broad *strategy* of regimes of practice, and the programmes that endeavour to shape them and prioritise certain purposeful elements. Regimes of practice thus constitute an assemblage of functions and logics which cannot be

reduced to the desires of a specific actor, or programme ethos – but do have an identifiable ‘matrix of ends and purposes’ (Dean, 2010; p32).

Despite this rather technical language, an analytics of government basically represents a way to explore how we govern ourselves and others; and how we are governed by others within a multitude of different governmental regimes. It encourages a critical questioning of how such regimes are formed, how they then function, and finally how they are transformed (Dean, 2010; p33). It is premised on an understanding of government in liberal and neoliberal societies as governing through freedom, rather than traditional forms of sovereign or disciplinary power (whilst accepting that both sovereign and disciplinary power coexist in contemporary forms of governing) seeing subjects as ‘living individuals, as members of a population, as resources to be fostered, to be used and to be optimized’ (Dean, 2010; p29). It sees governing as an ‘art’ that prioritises the (economic and health) wellbeing of the population above all else (Foucault, 2007).

Dean (2010) draws on the work of Deleuze in the designation of his ‘analytics of government’ framework, and his essay ‘What is a *dispositif*?’ (Deleuze, 1992) The word *dispositive* has no direct English translation, but ‘social apparatus’ or ‘device’ seems to be the most useful way of understanding the word’s meaning. Deleuze’s language is figurative and refers to non-linear lines and folds of knowledge. He identifies four of the key lines which run through the dimensions of social apparatus:

‘These apparatuses, then, are composed of the following elements: lines of visibility and enunciation, lines of force, lines of subjectification, lines of splitting, breakage, fracture, all of which mingle and criss-cross and mingle together’ (Deleuze, 1992; p162)

So these four strands of governing which exist independently converge on an analytic level. By considering them independently and interactively however, we can deduct a more comprehensive insight in to how methods of governing interact with each other in a historical and practical sense.

For this thesis, as stated above, the key problematisation is the identification of stroke services in London as being below par and in need of improvement, the question then becomes – *how* is this to be remedied? What are the forms of knowledge, techniques and practices, identities and agencies, or ‘regimes of government’ employed to attend to this problem? (Dean, 2010; p40) Following Deleuze (1992), Dean defines four dimensions along which this can be analysed (Dean, 2010; p41). These have been adapted below to show how they might usefully be applied to this study:

1. *The examination of fields of visibility of government.* What is the significance of the documentation created as part of the reconfiguration process? What data is published when and why, by whom and for what purpose? Which outcomes will be publicised and which will not? Who and what are to be governed by the reconfiguration? We must consider the public (as potential patients) and professionals here. Are there some

areas which receive more or less attention than others, both in a figurative sense; primary versus acute care, and a spatial or economic sense, i.e. are some communities excluded?

2. *The concern for the technical aspect of government.* By what technical means are the values of the reconfiguration to be achieved, or 'by what means, mechanisms, procedures, instruments, tactics, techniques, technologies and vocabularies is authority constituted and rule accomplished?' (Dean, 2010; p42) what are the implications of the enhanced network control promised in the configuration – how are audit and clinical governance to be used and how will this be influenced by economic incentives and the role of leaders?

3. *The approach to government as rational and thoughtful activity.* Governmentality is the connection of government and thought. Essentially, what is the role of knowledge, expertise, rationality and interpretations of truth? 'Programmes of conduct are all the attempts to regulate, reform, organize and improve what occurs within regimes of practices in the name of a specific set of ends articulated with different degrees of explicitness and cogency.' (Dean, 2010; p43) Here ideas relating to the nature and value of evidence, knowledge, calculability and EBHC can be explored.

4. *The attention to the formation of identities.* 'What forms of person are presupposed by different practices of government and what sorts of transformation do these practices seek?' (Dean, 2010; p43) What is expected of the roles to be played by different individuals and how is their conduct to be reformed? What are the implications for the

medical profession; both at a senior decision making level, in its involvement in the reconfiguration plans, and at a practical level, in how it is encouraged to change its practice in order to improve service delivery? How are clinical and managerial identities impacted upon throughout organisations both by the reconfiguration process and after the process for those affected by the changes?

Having described the central elements of an analytics of government and how they may be applied to the study of the reconfiguration of stroke services in London, there remain a number of important factors to make explicit about Dean's approach. Firstly, he suggests that we should extract the 'Utopian' element of government. This refers to the belief that policies can be used to improve people, behaviour or societies in some way – an analytics of government ought to account for how the 'art' of government seeks to create a better world, or way of doing things (Dean, 2010; p44). Secondly, an analytics of government ought to be circumspect about the role of values and careful not to view regimes of practices as manifestations of values, but instead explore how 'values' are employed in governmental rationality: 'values, knowledge, techniques are all part of the mix of regimes of practice but none alone acts as guarantor of ultimate meaning' (Dean, 2010; p45).

This leads to a final point – an analytics of government should avoid 'global or radical' positions. Unlike the work of critical theorists both in broader policy terms and for example within Critical Management Studies circles (e.g. Grey and Willmott, 2005), who tend to emphasise the alienating and coercive effects of management systems and increased surveillance and aim for some kind of liberation or emancipation, Dean suggests an analytics of government should not take a position on the 'goodness' or 'badness' of the activity of

governing (Dean, 2010; p46). This rejection of a 'radical' position reflects Dean's contention that a governmentality critique sees subjects and their 'freedom' as shaped within 'states of domination' – thus individuals undergo both forms of 'subjection' and 'subjectification' (Dean, 2010; p46). This resonates with the contention of Bevir (2010) that within a governmentality framework subjects operate through a 'situated agency' and are thus not autonomous and capable of 'standing outside relations of power and forms of domination' (Dean, 2010; p47).

This does not lead to a value neutral approach however but a subtle form of criticism:

'This is a form of criticism that seeks to make explicit the thought that, while often taking a material form, is largely tacit in the way we govern and are governed, and in the language, practices and techniques by which we do so. By making explicit the forms of rationality and thought that inhere in regimes of practices, by demonstrating the fragility of the ways in which we know ourselves and are asked to know ourselves, and the tissue of connections between how we know ourselves and how we govern and are governed, an analytics of government can remove the taken-for-granted character of these practices. The point of doing this is not to make the transformation of these practices appear inevitable or easier, but to open the space in which to think about how it is possible to do things in a different fashion, to highlight the points at which resistance and contestation bring an urgency to their transformation, and even to demonstrate the degree to which that transformation may prove difficult' (Dean, 2010; p48)

In this way, the political implications which flow from conducting an analytics of government are to highlight the contingency of forms of governing and management by problematising the dominant ways in which things are done. Rather than standing against all forms of domination, it offers an analysis of where, when and how specific forms of government and domination develop and allows us to question these – but not a ‘general prescription of what the result of such questioning might be’ (Dean, 2010; p50).

There are of course many other ways of applying Foucault’s work on governmentality to health care policy and management analysis. Significant scholarship over recent years has done so in myriad way – this literature is discussed in the following section.

3.4 Health care management studies drawing on governmentality

A review of the contemporary literature utilising key governmentality or broader Foucauldian themes applied to health care is presented below. This is useful in highlighting the analytic and thematic trends which have developed in this literature over the past two decades and distilling these into theoretically informed areas which will be described (see table 4) and explored empirically as part of this thesis.

Table 4: Foucauldian influenced health care studies

| Foucauldian theme | Questions/foci | References |
|--|---|--|
| <i>Neoliberalism and the politics of health care</i> | How are health care policy, management and professional power problematised in neoliberal thought? | Moon and Brown, 2000; Light, 2001; Joyce, 2001; Osborne, 1993; Johnson, 1995 |
| <i>Macro-level policy developments: resistance/control</i> | How do new forms of governance impact on traditional forms of professional autonomy and subjectivities? | Pickard, 2009; Levay and Waks, 2009; Kuhlmann and Allsop, 2008; Harrison and Dowswell, 2002; Gilbert, 2005; Flynn, 2002; Doolin, 2002; Chamberlain, 2010; Martin and Learmonth, 2010; Brown, 2011; Dent, 2003; Waring and Currie, 2009; Waring, 2007; Timmons, 2003; Rolfe and Gardner, 2006 |
| <i>Challenging the resistance/control framework</i> | Does disciplinary power highlighted by a Foucauldian critique foster ‘docile bodies’ or can this power be ‘productive’? | Numerato, 2011; Iedema and Rhodes, 2010; Martin et al, 2013 ; Gilbert, 2001 ; Dent, 2006 ; St Pierre and Holmes, 2008 ; Sheaff et al, 2004 |
| <i>EBM as a power/knowledge nexus</i> | Epistemic apparatus and systems of knowledge – how are these constructed and implemented? | Ferlie and McGivern, 2014; Ferlie et al, 2011; Ceci, 2004; Komporozos-Athanasίου et al, 2011 ; Hasselbladh and Bejerot, 2007 ; Greenhalgh and Shaw, 2008; Winch and Creedy, 2002 |

Neoliberalism and the politics of health care

Osborne (1993) draws on governmentality theory to present medicine as ‘field of government’ and produces a historical critique of the development of medicine and government in Britain in relation to liberal and neoliberal political rationalities. He argues that neoliberalism heralds a new form of medical government in which ‘physicians are enrolled – alongside managers certainly – as something of administrators and economists themselves’ (Osborne, 1993; p353). In this way, the roles played by medics, and the identities they take on are increasingly to be shaped by management and economic rationalities

reflecting the broader political circumstance. This is linked to Quality Improvement and audit (though not EBM in this early paper) initiatives. Likewise, Johnson (1995) produces an overview of various theoretical debates related to how best to conceptualise professional relations both within medical groups and with the state, and an eloquent argument as to why a Foucauldian approach is potentially more useful than the traditional medical sociology approaches offered by Freidson (1973), and Abbott (1988). Johnson uses Foucault's rejection of the state as a defined, identifiable entity, and the insight that we may conceive of the state as an amorphous collection of apparatuses, knowledge and control mechanisms – thus eliminating the duality of profession/state which Freidson places at the heart of his thesis. Johnson's achievement is to demonstrate that the complex interpretation of the relations which constitute the state inherent in a governmentality approach is sophisticated enough to highlight the weakness in Freidson and Abbott's respective paradigms, whilst retaining their indubitably useful components.

Light (2001) applies a governmentality approach to critique how the managed competition ethos at the heart of the Conservative party's NHS reforms of the 1980s and 1990s impacted upon the 'conduct of conduct' of health care professionals emphasising fragmentation and failed regimes of accountability. Once more taking a macro-level approach focused on Conservative reforms from 1992-97 and building on the work of Miller and Rose (1990) Moon and Brown (2000) discuss 'spatializing language' as an 'art of government' through which they emphasise the importance of 'local' decision making and responsive management symbolically distancing government itself from the act of governance (Moon and Brown, 2000; p74). Power is seen to be dispersed as the role of local level players in the quasi-market are rhetorically engaged in decision making on behalf of local populations. Drawing on

empirical data based on interviews with Health Authority managers, Joyce (2001) highlights the neoliberal continuation of governance from Major to Blair governments and suggests:

‘Using the Foucauldian framework of “governmentality” it can be seen that the discourse of commissioning, rationing and priority setting in the NHS, and the institutional practices in which it is embedded, operate at a much more fundamental level than surface political activity would indicate... radical change in the governance of health care only comes about through a shift in the problematisation of liberal governance, not merely in the transition of one political regime to another’ (Joyce, 2001; p612)

Building on the work of the London Governmentalists and an interest in political power ‘beyond the state’ this first application of governmentality influenced work opened the door for a new critique of the shifting health care governance and its impacts upon managers and professionals. This is discussed below.

Macro-level policy developments: resistance and control

There is a wide literature which focuses on the impact of management reforms upon the medical profession (Numerato et al, 2011) and the merging of managerial and professional jurisdictions (Waring and Currie, 2009). An important section of this literature draws on Foucauldian themes and governmentality in particular. A number of studies do this with a focus at the macro-level of policy developments and draw on earlier work by Johnson (1995)

and Osborne (1993). Pickard (2009) for example draws on a governmentality critique to demonstrate the contingent and fluctuating nature of professional-government relations in contemporary health care policy focusing on what she terms as ‘restratification’ of the medical profession demonstrated with reference to the ‘professionalization’ of GPs with a Special Interest. Restratisation refers to the process by which some doctors take on managerial responsibility over their peers; which along with the adoption of EBM and other ‘externally validated procedures’ leads them to subject themselves to ‘liberal rationalities’ (Pickard, 2009; p255). She highlights the importance of ‘advanced liberal’ Discourses such as ‘accountability, transparency, efficiency and consumerism’ in reconstructing professional identities in alliance with ‘managerial rather than occupational autonomy’ (Pickard, 2009; p264). Dent (2003) suggests the professional-managerial dividing line is being eroded (p108). Combining a governmentality critique of micro-level doctor-manager relations with an Actor Network Theory approach he demonstrates the collective and tactically advantageous ways in which professionals become ‘enrolled’ or ‘enmeshed’ in managerial Discourse and come to accept managerial as well as clinical responsibilities – crucially, they remain ‘less accessible to the disciplinary power of management’ than other non-professionalised staff in other studies by Townley (1993) and Fournier (1999) (Dent, 2003; p123).

Flynn (2002) explores the introduction of clinical governance to the NHS through the prism of governmentality. The policy is interpreted as an attempt to increase oversight of the medical profession thereby augmenting control and surveillance. Flynn emphasises the disciplinary elements of modern society and organisational life (p163) and the self-governing aspect of control following Dean (2010). Individuals become ‘co-opted’ into audit culture as a process of subjectification as values of the dominant Discourse are internalised. Clinical governance represents:

‘[A] clear example of placing the responsibility on clinicians and incorporating them as active participants in their own (self-) surveillance, and distancing this process from conventional notions of bureaucratic or managerial control’ (Flynn, 2002; p164)

Flynn notes that governmental allusions to ethical or professional values (for example by highlighting the unacceptability of wide variations in clinical practice (p164)) may be central to the ‘responsibilisation’ and co-option of professionals into these self-surveillance regimes. He suggests that clinical governance might be seen as a move towards ‘encoded knowledge’ linked to the concept of ‘soft bureaucracy’ (Courpasson, 2000). Once more focused at the macro-level, Martin and Learmonth (2012) present a critical account of ‘leadership discourse’ in UK health policy and argue that it aligns the subjectivities of staff with policy intentions making ‘implementation not just everyone’s responsibility, but part of everyone’s sense of self’ (Martin and Learmonth, 2012; p281). They suggest that the extension of surveillance may have malign consequences – particularly for staff near the bottom of the hierarchy (Martin and Learmonth, 2012; p287).

A number of empirically grounded studies drawing upon robust micro-level data focus on the intricacies of resistance and control within and between managerial and medical communities drawing on governmentality frameworks. Timmons (2003) explores the ‘failed’ implementation of an ‘electronic panopticon’ aimed at increased surveillance and regulation of nursing practice in the NHS. His study focuses on the resistance which the programme faced whilst noting the simultaneous compliance from some quarters – he terms the

relationship between the nurses as subjects of the computerised systems for the production of care plans and the programme itself as 'resistive compliance' (Timmons, 2003; p145).

Resistance manifested itself not in an outright refusal to use the systems, but rather a tendency to delay and engage in critical discourse with respect to the systems. More effective means to increase control over nursing practice were linked to external threats of litigation (more than internal disciplinary measures) and recourse to the nurses' 'own culture and values' which is linked by Timmons to the effects of governmentality, as well as direct line management by senior nurses:

'[T]he management of these hospitals had an interest in extending surveillance of nursing practice, this was not (largely) happening. This was because the nurses were able to ignore or circumvent the surveillance capability of the computer systems, as they knew there were few effective sanctions that the management were prepared to use to secure full compliance with the system. One of the ways in which they were able to sustain this position was by deployment of rhetorical strategies based on the perceived "fundamental values" of nursing.' (Timmons, 2003; p151)

So the surveillance failed because management lacked the 'hard' techniques to enforce compliance, but also – and more importantly – the systems failed to align with the nurses' ethical desires, and they could reject the system by presenting their professional identity as antithetical to the aims of the management. This suggests that the disciplinary power of the surveillance technique is hindered by an inability to demonstrate the furtherance of professional goals resulting in 'resistive compliance'. Further studies have demonstrated the

resistance of professionals to new forms of governance which fail to account for ‘experiential knowledge’ and professional values (Chamberlain, 2010; Brown, 2011).

Doolin (2002) extends understanding of this issue with his single case study of government attempts to ‘control, curtail or influence’ the professional autonomy of clinicians in a New Zealand hospital. He explores how ‘enterprise discourse’ was accepted, resisted or subverted by clinicians. It is important to emphasise here that this discourse emanates from a political and management angle – like some of the political targets resisted in the Timmons (2003) Brown (2011) and Chamberlain (2010) studies cited above – in contrast to EBHC which, as argued in the previous chapter, whilst linked to management rhetoric may be seen as being more closely aligned to clinical goal setting (Timmermans and Berg, 2003). It might be suggested that this is significant in fostering support amongst clinicians (Ferlie et al, 2011; Ferlie and McGivern, 2014). A further important point relates to how clinicians perceive the effects of policies will impact upon them in relation to colleagues and management:

‘Reaction to the introduction of the new identifications for clinicians depended to a large extent on whether individual clinicians perceived themselves as controlling or using the organizational changes to improve their own position, or that of their clinical service, or as being controlled by them... resistance arose from the positioning of clinicians as subjects within an alternative, medical professional, discourse (Fairclough, 1995)’ (Doolin, 2002; p382)

Where changes can be capitalised upon by professionals (on behalf of themselves or their services) they are more likely to be accepted, rather than resisted or subverted. There are two points which follow on from this – a management Discourse which may be interpreted as being aligned to medical, nursing, and professional goals (such as EBHC) is potentially better placed to exploit this, and secondly, the jurisdictional position (Abbott, 1988) of different professional disciplines may be significant in influencing the extent to which organisational changes may be seen to improve or hinder the relative position of clinicians and their services. For example, a service with a historical low status (e.g. stroke medicine) may be more amenable to management Discourse than a historically high status service such as surgery. Indeed, an empirical finding of Waring's (2007) ethnographic study of patient safety programmes in an English hospital is that surgery alone was the one department he studied which refused to enhance their Quality Improvement techniques by drawing on the resources of the management intervention (Waring, 2007; p172). His findings overall suggest that doctors increasingly come to 'adapt' their regulatory practice. He suggests they are perceptibly performing a form of self-surveillance which 'ultimately serves to negate the need for more or better management' (Waring, 2007; p164). He speculates that it may be useful to consider how management Discourse is permeating the medical profession as a form of governmentality rather than focusing on ongoing extensions of general management *over* medicine. Again like EBHC, it might be argued that there is an 'ethical' element to the instigation of patient safety regimes – whilst they clearly are linked to Discourses of management they also appeal to the professional desire to achieve good practice.

Harrison and Dowswell (2002) describe an increase in 'bureaucratic accountability' and 'professional restratification' amongst GPs in the North of England and find very little evidence of resistance to the apparent reduction in autonomy faced by these GPs (Harrison

and Dowswell, 2002; p221). They suggest this is an example of Foucauldian ‘panoptic surveillance’ linked to a state strategy of bureaucratising medicine drawing on the political economy of EBM which they link to financial pressures on the NHS, the co-option of senior level clinical elites, the effects of protocolisation via NICE and NSFs and finally the role of medical managerial hybrids who ‘are more likely to behave as managers than as clinicians; that is, their role is primarily determined by social structure rather than professional socialisation’ (Harrison and Dowswell, 2002; p223). Gilbert (2005) likewise emphasises the disciplinary power of management encroaching over clinical remits which ‘colonizes professional activity’ and challenges professional autonomy in a nursing context highlighting the extension of managerial control using a governmentality framework.

Levay and Waks (2009) attempt to move beyond the control/resistance framework with their work on ‘soft autonomy.’ They suggest that the pursuit of transparency in health care is more complex than suggested by the traditional management/professional divide. They draw on the work of Abbott (1988) to highlight the jurisdictional claims of competing professions and disciplines and Freidson’s stratification thesis (1994; 2001) signifying the different roles of elites and ordinary practitioners. They show empirically how professionals actively involve themselves in the practice of making their work ‘auditable’ – but this does not lead to disempowerment, or a loss of autonomy – ‘on the contrary, they still managed to control many of the premises and criteria of evaluation. Professionals were neither independent in evaluating their own work, nor in the hands of external evaluators, but enjoyed a negotiated “soft” professional autonomy’ (Levay and Waks, 2009; p523). In a similar vein Kuhlmann and Allsop (2008) offer professional ‘self-regulation’ as a useful concept to understand change in professional governance which again aims to transcend the control/resistance

framework which permeates much of the literature around managerialisation, professionalism and governance.

Challenging the resistance and control framework

‘[C]oncepts such as co-optation, adaptation, negotiation or resistance remain located within the cultural incorporation/opposition, in other words hegemony/resistance framework and tend to situate the result of the dynamics between professional practice and managerial logic on a continuum between resistance to and compliance with managerialism. We suggest that this conceptualisation tends to overemphasise the importance of a conflictual model and fails to adequately capture the more complex role played by the boundary fields of epidemiology or EBM.’ (Numerato et al, 2011; p637)

Numerato et al (2011) suggest that the ‘hermeneutics of suspicion’ central to social theory and reflected in the sociology of health care writings has tended to marginalise calls for greater consideration of epidemiological perspectives that emphasise how professional autonomy (rather than managerial surveillance) may be extended. Furthermore, questions related to professional ethics and medical responsibility in the construction of a quality health care system as ‘collective good’ require further exploration (Numerato et al, 2011; p638).

Iedema and Rhodes (2010) suggest that organisational surveillance may potentially ‘open up an ethical space of self and mutual care on the part of those subject to it’ (Iedema and

Rhodes, 2010; p200) so that disciplinary power may be productive rather than repressive by leading to a process of subjectification rather than subjection where agents actively emulate the regulation of discipline, reflectively and creatively responding to reality (Iedema and Rhodes, 2010; p203). Rather than shrinking the space in which professionals have to operate freely – ‘being seen’ may conversely expand such space in areas which may have previously been hidden (Iedema and Rhodes, 2010; p211). In this way, a disciplinary practice such as audit for example may be welcomed by professionals if it chimes with their ethical desires:

‘For surveillance to be experienced as subjugating it needs to be iteratively confirmed as operating within that intention *and no other* on the part of those who wield it. This means that surveillance is not self-evidently alienating, and that it can engender feelings of care and being cared for. These arguments offer a warning against oversimplifying the dynamics at play when surveillance is practiced, as well as against overstating the effects of the surveillant gaze’. (Iedema and Rhodes, 2010; p212: emphasis added)

This moves the debate onto the interaction between discipline and governmentality in contemporary health care. A crucial contribution to the interpretation of this debate is provided by Martin et al (2013). They first draw attention to the ways in which disciplinary power and governmentality have been applied to contemporary health care studies, but as alternatives, or even contradictory ways. For example Rose’s (1993) classic early work applying governmentality to social problems emphasises a strong distinction between disciplinary power and the enactment of governmentality (Martin et al, 2013; p7; Elden, 2002; p248) whilst Elden argues that Foucault’s work shows ‘no strict differentiation

between the two concerns' (Elden, 2002; p248). Martin et al (2013) highlight the dominance of macro-level Foucauldian inspired critiques which draw upon theories of disciplinary power and governmentality and suggest there is a lack of scholarship exploring this at the micro-level, and how it may impact upon influencing professional behaviour. This leads to a questioning of how 'discipline and governmentality interact in complex contemporary governance' (Martin et al, 2013; p7). Empirically they then demonstrate that whilst the *standardizing* regimes of disciplinary power (surveillance, panoptic gaze, increased monitoring and accountability) are significant in influencing clinical practice – they rely upon techniques of governmentality for successful *implementation* by speaking to 'professional subjectivities' and finding their power in 'their appeal to professional values and rationality' (Martin et al, 2013; p16). They noted the importance of clinical leadership, transformative narratives and discursive forums promoting professional reflective practice in creating contexts which mediated the disciplinary power of regimes of Quality Improvement and patient safety and rendered them open to inculcate an ethical impact upon the agency of active professional subjects. Moreover, this occurred as a form of communal negotiation rather than as an individual phenomenon (Martin et al, 2013).

This is not merely about control versus resistance then; rather it is about the interplay between disciplinary power and governmentality. Sheaff, et al (2004), employ a governmentality approach to investigate Clinical Governance procedures in Primary Care, arguing that these are less formalised than in acute care settings. Professional ownership of the 'ambiguous' governance procedures is key. The study concludes that little may have changed in practice following the introduction of Clinical Governance:

‘[M]edical networks still influence GPs more than NHS managers do. The profession continues to exercise self-regulation as a lesser evil than managerial control...

Professional governmentality and discipline remain the backbone of medical self-regulation.’ (Sheaff et al, 2004; p 100)

Rather than Foucauldian ‘docility’ it was the recourse to ‘discursive disciplines’ which legitimated clinical governance regimes allied with positive incentives which were significant empirically in this study (Sheaff et al, 2004; p 101). Dent (2006) argues that professionalism in health care has become ‘responsibilized’ relying more on ‘disciplinary logic’ than autonomous expertise: ‘however, any managerial ascendancy is offset by the governmentality role of the medical profession’ (Dent, 2006; p459). This is linked to rhetorical policy moves towards patient choice. Gilbert (2001) and St Pierre and Holmes (2008) explore disciplinary power and processes of ethical construction of nursing identities through Foucauldian analysis producing contrasting pictures of how nursing practice and subjectivities are fostered.

EBM as a power/knowledge nexus

A further development within the health care literature draws upon Foucauldian analytic methods to explore the episteme of EBHC and considers how systems of knowledge are constructed and implemented in what is termed the ‘power/knowledge nexus’ (Ferlie et al, 2011; Ferlie and McGivern, 2014). Ceci (2004) explores how knowledge and truth are understood from a Foucauldian perspective in a paper which investigates retrospectively lessons to be learned following an enquiry in to a number of deaths of patients following

paediatric cardiac surgery in 1994 in Canada. She questions the nature of knowledge and knowing amongst different professional groups in an attempt to increase understanding as to why nursing concerns with an individual surgeon's practice were not acted upon. This approach details the context of credibility in professional relations and what defines and limits nurses' actions. Ceci cites the Foucauldian disjuncture between truth and knowledge, with the implication that truth is constructed by specific forms of knowledge which may be accepted by one practical community and disputed by another. She suggests that the relatively weak power of the nurses meant that their concerns were easily disregarded, and that those in 'privileged positions' derived via institutional and epistemic authority set the agenda vis a vis what reality and truth are conceived of within the context of the inquiry into the performance of the unit. There is a danger of over-extending authority and underemphasising accountability in health care if this imbalance of power relations in truth construction is ignored.

Shaw and Greenhalgh (2008) employ a discourse analysis technique to investigate the contextual factors (historical, cultural, economic, and epistemic) which drive health care research. The authors suggest that a government led ideology in the interests of '*UK plc*' has pushed bio-scientific RCT centric agenda onto the research community since the 1970s in order to create an economic driver for the nation. They place the role of primary care in this context and question in whose interest this specific 'science' functions. They argue that 'health research policy shapes, and is shaped by, a knowledge-based economy discourse.' (Shaw and Greenhalgh, 2008; p 2510) Analysis of government documents confirms this trend. Income generating science dominates research. This increases the power of an academic medical elite based at influential institutions. Epidemiological and quantitative methodologies drive health research and define the parameters in which research discourse

occurs and medical elite leaders are identified. This is significant when considering the role of EBM in creation of knowledge and evidence and the construction of health policy.

Winch and Creedy (2002) apply a governmentality approach to how nursing is being changed by the evidence-based health care movement in Australia. The authors use Dean's (1999) analytics of government framework very fruitfully. They argue at the macro-level that evidence based guidelines: 'produced by the governmental technique of the systematic review are pre-eminent in any "truth" taxonomy of health-care as it validates and promotes knowledge that has been reviewed according to the principles of positivist science' (Winch and Creedy, 2002; p157). At the micro-level this leads to 'active fashioning of the self' as individual nurses change their outlooks and practices in light of this new knowledge and affiliated trends. The authors suggests that new forms of visibility of nursing are apparent due to the pervasion of evidence based nursing – increased nurse led research and practical reflexivity – 'mapping of nursing work' is essential for 'the public scrutiny required of liberal political government'. The new ways of practicing nursing may lead to an increase in the influence of 'science' at the cost of traditional 'intuitive' methodologies of practice. This scientific dominance extends into new codes for the production of nursing knowledge – the authors suggesting that evidence-based research work is now the only paradigm for researchers to employ to avoid becoming 'invisible'.

Ferlie et al (2011) compare two different cancer networks – using urology service reconfiguration as a tracer issue to evaluate the applicability of a governmentality approach to analysis - and find evidence of a shift towards hybrid forms of governance with Foucauldian elements co-existing with surviving hierarchical elements. They suggest it is possible to

discern five themes of Foucauldian health care governance as potentially influential in driving health care policy; the existence of a power/knowledge nexus and the institutionalisation of EBM, self-regulation and surveillance within central frameworks (clinical governance), transparency of data (audit), reformed identities at work (clinical managerial hybrids), biopolitics and the government of populations – suggesting:

‘Population level evidence based guidelines leading to service reconfigurations across territories are a form of biopower’ (Ferlie et al, 2011; p12)

The authors question whether cancer care is specific (high levels of investment, closeness to the biomedical trials world) in these findings, or if other clinical (and non-clinical) arenas are structured in similar ways in health care. Further work by Ferlie and McGivern (2013) extends this analysis. They apply an ‘Anglo-governmentality’ perspective to case studies of; (1) NICE – to explore macro-level governance and the institution of the power/knowledge nexus via ‘pervasive grey sciences’ behind evidence based guidelines; (2) sexual health clinical network – to explore the micro-level process of ‘subjectification’ undertaken by local governing agents drawing on Foucault’s work on ‘technology of the self’ and add to this by applying Foucault’s work on ‘pastoral power.’ This work is of significance in the debate over the relationship between disciplinary power and governmentality (Martin et al, 2013):

‘In the local sexual health network, NPM style line managers have been supplanted by professional-managerial hybrids who identify with the EBM agenda. These hybrids adopt a hands on and energised style in local enactment. They draw upon the

disciplinary power of local clinical audit against national standards and clinical “peer pressure” to internalise and comply with evidence-based standards. These hybrids exhibit long term tracks of career development consistent with a technology of the self perspective, migrating to more managerial roles and perhaps even identities over time. They can be seen as using a form of “pastoral power” in relation to their clinical peers.’ (Ferlie and McGivern, 2013; p36)

A further finding is how the ‘grey sciences’ conform to a different pattern than the ‘accountization’ identified by Miller and Rose (2008) – they find again a ‘hybrid’ clinical-economic knowledge base in their NICE case study (Ferlie and McGivern, 2013; p37). Other governmentality studies which explore the power/knowledge nexus related to EBM include Hasselbladh and Bejerot (2007) who analyse macro-level Swedish health care reforms and the role of ‘grey sciences’ in the development of technologies of agency and performance (Dean, 2010) and Komporozos-Asthanasiou et al (2011) who compare the different ways in which (evidence based) stroke care has been reformed in Canada and the UK and the relative importance of rhetorical ‘knowledge translation’ strategies through a discourse analysis approach.

In summary, this review identified a number of significant foci and questions pertinent to empirical exploration using a Foucauldian influenced theoretical approach to contemporary health care policy and management. These were presented in Table 4 alongside a number of key research questions. The review began with a discussion of important texts published between 1993-2001 which focused on concepts around neoliberalism and the changing political state of health care in the light of the Conservative administrations since 1979.

Drawing on the seminal work of the London Governmentalists a number of scholars began to apply Foucault's work on governmentality to explore how health care politics and professional power were problematised in neoliberal thought. This literature fusing governmentality theory with contemporary health care management issues was followed by a new set of authors from the start of this century. These included Organisational Studies, Management and Health Service Research scholars who began to apply governmentality as a framework to unpack the ways in which managerialisation encroached upon traditional forms of medical autonomy often drawing on the (non-health focused) Organisational Studies work of Zuboff (1988); Reed (1996); Townley (1993); and Clegg (1994). Whilst the 1990s scholars attempted to apply Foucauldian thought to macro-level historical political changes in policy and governance, this following cohort came to focus more heavily upon issues of resistance and control – or the 'hegemony/resistance framework' (Numerato et al, 2011).

These studies also included empirical elements and a concern with micro-level interactions rather than just macro-level concerns. A key interest of this literature then became how to account for the blurring of the boundaries between management and medicine for doctors who take on management positions and implications for professional autonomy. An important thematic point relating to Foucauldian theory which emerged here rested upon the extent to which authors emphasised the disciplinary elements of the governmentality framework and how this may be seen to have led to an internalisation of management Discourse by health care professionals. Discussions around 'co-optation' (Waring and Currie, 2009); 'adaptive regulation' (Waring, 2007); 'resistive compliance' (Timmons, 2003) and more overt forms of resistance are explored. A further theme that developed focused more overtly on the ways in which a governmentality critique may account for the realisation of ethical desires for professionals with a stronger closeness to Foucault's later work relating to

‘technologies of the self’ (Ferlie et al, 2011; Ferlie and McGivern, 2013; Martin et al, 2013) – this approach down plays the conflictual ‘hegemony/resistance framework’ and is worthy of further exploration. There is another important but smaller concern developed in the literature which focused upon EBM as a power/knowledge nexus within a governmentality framework – mostly at the macro-level (Shaw and Greenhalgh, 2008; Ferlie and McGivern, 2013), but also with some studies focused on the micro-level – these studies explore the epistemic apparatus constructed and employed to aid the implementation of evidence based regimes of practice and can potentially shed light on and help progress from the ‘hegemony/resistance framework’ (Numerato et al, 2011) by offering an important insight into the ways disciplinary power and governmentality interact with active subjectification and technologies of the self for health care professionals and managers.

It is worth noting that there are some surprisingly under-researched issues identified in this review. The first point is that there is preponderance to apply Foucauldian theory to uni-professional groups (e.g. doctors *or* nurses) but few attempts are made to question how changes in governance arrangements impact in inter-professional terms within and across multi-professional or disciplinary teams. Linked to this, there appears to be little research on how governance changes impact upon staff with different power positions within organisational hierarchies. There appears to be little research on how EBHC as a Discourse affects managers (as opposed to clinicians) and also, whilst many studies take a macro-level view of governmentality in health care and/or a micro-level interest in professional relations – few studies apply Foucauldian theory to explore strategic level change and service reconfiguration – and little use of the concept of ‘biopolitics’ is made in the literature reviewed.

3.5 Summary

This chapter introduced Foucault's work on governmentality and discussed how it interacts with key themes identified in his analysis of modern societies. Dean's (2010) analytics of government framework was introduced and its potential utility as a tool to perform an analysis of the reconfiguration of stroke services in London was described. Finally, a review of the key contemporary Foucauldian influenced health care management texts was described highlighting the themes of changing forms of governance, impacts upon autonomy and the role of EBHC.

The chapter built on the previous literature review chapter suggesting that the process of '*standardisation*' (Timmermans and Berg, 2003) central to evidence based health care may be interpreted as a form of disciplinary power (Foucault, 1977), which 'operates through processes in which individuals are measured and compared, using certain norms or standards, to produce hierarchies of differentiation and impose a value on them' (Brown and Lewis, 2011 p871). It might be suggested that the formalised '*protocolisation*' and increased data monitoring central to programmes to reform health care (EBHC, QI, Patient Safety, clinical governance, medical audit) have opened up medicine and health care more broadly to the performative gaze of government actors and agencies. However, these programmes are not necessarily omnipotent but may be adapted by those they target (Doolin, 2002; 2004; Pope, 2003; Timmermans and Berg, 2003; Timmons, 2003; Thomas and Davies, 2005; Waring, 2007; Brown and Lewis, 2011). The process of '*enactment*' of evidence based health care (Dopson and Fitzgerald, 2005) is influenced by not only disciplinary power, but also by

forms of governmentality which impact upon the subjectivities of clinicians and managers at the micro-level (Sheaff et al, 2004; Dent, 2006; Martin et al, 2013).

Chapter IV

Methodology

4.1 Introduction

This chapter has a number of aims. Primary amongst these is to describe and justify the research design. The approach is qualitative, and based on a case study design which focuses on macro-level change in stroke care design across London. Within this there is a second embedded case study focusing on change at the micro-level in one London hospital. The chapter will detail the three chosen data collection methods and justify the rationale behind these choices. It will describe the chosen methods of data analysis and reflect on the strengths and limitations of the overall methodological approach.

In the first section the research question will be re-stated alongside a discussion of the epistemological approach behind the research. Then the research design will be presented – this will include a discussion around the research model and timeframe, sampling and selection issues, and a discussion of the ethical concerns that arose as part of this work and how these were handled. Following this, the chapter will describe in detail how and when the different data were collected and analysed. It will reflect on the problems encountered at different points over the five years spent producing the thesis, how such problems were overcome, as well as discussing how these factors and others – such as the researcher's subjective views and beliefs may have impacted upon the results presented in the later

chapters so as to provide the reader with as thorough an account of the research process as possible.

4.2 Philosophical approach

This thesis seeks to explore the following research question:

What was the role played by evidence in the reconfiguration of stroke services in London?

This is an interpretive question that is better suited to qualitative than quantitative methodologies (Savage, 2000; Britten, 2005). It requires the researcher to make a number of important decisions in terms of what ‘evidence’ is considered to be and which ‘evidence’ will be analysed, as well as a consideration of who creates, interprets and uses this ‘evidence’ and for what means. Beyond this, the researcher has to make decisions about how to interpret the data generated via the chosen data collections methods – how should actions, and both written and spoken words be interpreted? How ought contrasting accounts of specific phenomena be analysed, presented and resolved – if indeed they are resolvable? Reflecting this, the researcher must be clear about their ontological and epistemological assumptions and justify these.

My approach rejects the belief that an objective, knowable reality exists, and the role of social science research is to employ empiricist techniques to uncover and present this reality.

Rather, my starting premise is that each of us constructs our own reality, and that therefore a universal, objectively knowable truth, such as those prioritised in the natural sciences is questionable, and the importation of such techniques to social science research is problematic (Hammersley and Atkinson, 1983; Bowling, 2009). The aim of qualitative research is to interpret people's subjective experiences and convey a collective reality; and specifically in this piece of research, to highlight how evidence is used and interpreted by different individuals and communities and how this impacts on organisational and strategic decisions.

As part of the preparatory work for the thesis a number of different methodological approaches to qualitative research were considered. Ultimately an approach following Alvesson and Skoldberg (2000) is applied to the research. These authors suggest that social science research should be reflexive, and take into account the various different ways of doing research, their respective merits and drawbacks, and emphasises that when performing research and analysing data, the researcher ought to reflect upon the various different methodologies that could be used in order to produce a rounded picture of the area s/he is studying. An important decision was the extent to which the research methodology should prioritise induction or deduction – both are employed in this thesis, the inductive element follows some of the principles of Grounded Theory (Glaser and Strauss, 1967) especially those of 'theoretical sampling' and the 'constant comparison' method of data analysis. The latter of these aids a reflexive response to emergent findings whilst working through the research. This is helpful when allied with a clear theoretical framework to which these inferences may be applied to reflexively tweak and refine the theoretical approach. Problems may arise when this is done free from any organising theoretical base – relying on 'common sense' and an objectivity that can be legitimately questioned. So whilst there are useful concepts to be extracted from a Grounded Theory approach; these have a greater coherent

utility when applied alongside a reflective, critical approach based on established, explicit theory (Alvesson and Skoldberg, 2000).

This thesis requires a wide perspective of the macro political factors external to the political process driving change forward internally. For these reasons, Critical and Postmodernist approaches which contextualise historical and social factors (Alvesson and Skoldberg; 2000; p110) are apposite to this study with its governmentality approach. Alvesson and Deetz (1999; p111) have highlighted the relevance of Foucault's work for a critical research approach in management studies. They suggest that most management research is built on modernist foundations and that the aim of critical research here is to challenge the status quo and the 'instrumentalization of people and nature through the use of scientific-technical knowledge' (Alvesson and Deetz, 1999; p13). Another theme of interest in critical research is how information is not only distributed, but produced, and how expertise, claims of truth and power dynamics can be interpreted and understood within this context (Alvesson and Deetz, 1999; p47).

There are dangers in taking a purely critical approach that prioritises an 'emancipatory' truth (Dean, 2010); likewise, the contention that knowledge is always interest driven can be seen as rather reductionist and driven by a non-reflexive urge to highlight negative societal features (Alvesson and Skoldberg; 2000). So a critical approach must be tempered by an awareness of these dangers, and must be sufficiently reflexive to counter them. In this light, such an approach complements a governmentality critique (see section 3 of chapter III). A major drawback of some postmodernist approaches and how they incorporate empirical data is that they tend to focus more on how *not* to do research than how to do it (Alvesson and

Skoldberg; 2000). However an understanding of the themes underlined by a postmodernist approach is clearly essential to my study. Hence, Doolin (1998; 2004) adopted a ‘critical interpretivist’ approach in his Foucauldian influenced study looking at resistance to information system implementation on the part of clinicians in a New Zealand hospital. This approach reflects the socially constructed nature of organisations and their reality (Doolin, 2004) and also that: ‘interpretivism asserts that the positivist methodology of the natural sciences is inadequate for the understanding of human action’ whilst critically questioning assumptions behind the organisational status quo (Doolin, 1998).

Furthermore, the question of reflexivity and its importance needs to be highlighted. Steier (1991) employs a constructionist approach to explore reflexivity, or ‘a turning back on oneself.’ He focuses on the question of how the language of others and their ways of constructing meaning can be understood by the researcher. Steier views research as a ‘translation process’ on various levels both between researcher and reciprocator and internal to the researcher. Therefore research becomes a process of invention and intervention. Steier presents a compelling method to reconcile this paradox: ‘to see research as a co-constructive process’ between the researcher and the researched:

“‘The system’ is one that emerges in a hermeneutic merging in the investigative process, and includes the researcher, and his or her modelling processes (making research autobiographical), co-constructing that system in conversation with an “other(s)”’ (Steier, 1991; p179)

By being aware of the centrality of the researcher in this process, research can become reflexive. At the heart of this approach lies a cognizance that reality is constructed, and that together, the researcher and reciprocator create a shared understanding of this reality. The role of language and its context specificity and potential ambiguity has to be understood and acted on reflectively by the researcher. Researchers bring their own interpretation of another's interpretation of *a reality* but being open about this and not employing the fallacy that they are 'discovering' *the verifiable reality*. Alvesson and Skoldberg (2000) broaden out a conception of reflexivity that cuts across interpretive levels, suggesting a kind of 'quadri-hermeneutics' – based on elements from Grounded Theory, Hermeneutics, Critical and Postmodernist theories – essentially, 'reflection occurs when one mode of thought is confronted by another' (Alvesson and Skoldberg; 2000 p247). This approach has much to recommend it as it may allow the researcher to be conscious of the benefits and pitfalls of the various approaches to empirical work and wider theoretical implications to the collection, framing and analysis of qualitative data.

In philosophical terms, this thesis employs a reflexive critical stance in line with the aims of the analytics of government (Dean, 2010) approach. This framework encourages the researcher not to take the spoken or written word 'at face value' – rather it emphasises an exploration of language and discourse in its complexity – focusing on the 'non-subjective intentionality' of governmental reform programmes. This makes it an inherently interpretive endeavour. Actors possess a 'situated agency' (Bevir, 2010) in that they are influenced by, yet also influence, aspects of developing regimes of government and practice. So in the analysis of generated data, it is important to explore what is made visible, or left opaque and challenge this – in this way, discourse is not examined uncritically – but neither is it discounted. Language may be imbued with more than one meaning at the same time –

discourse may be built upon ambiguities that have organisational significance. An approach which combines inductive and deductive analysis with a critical awareness facilitates exploration of these types of concerns. The following section will now detail the fundamentals of the research design in greater depth.

4.3 Research Design

The research combined semi-structured interviews, observations of meetings and documentary analysis. The aim was to understand more about behaviour in its institutional context (Green and Britten, 1998). The chosen approach enabled an examination of the implicit and explicit implications and motivations behind individuals' actions rather than quantification. The research consisted of two case studies (I and II). Case study I focused on the macro-level policy and governance changes of the reconfiguration of stroke services across the whole of London. Case study II was embedded within case study I and focused on the micro-level policy and governance changes in one London hospital (given the anonymised pseudonym: *Kenworthy hospital*) following the changes negotiated, designed and implemented at a pan-London level. This case study approach focused in detail and in depth (in both practical and thematic terms) on the processes and principles behind service delivery changes – what Stake (1995) might term 'particularisation.' Figure 2 below, graphically represents the case study approach:

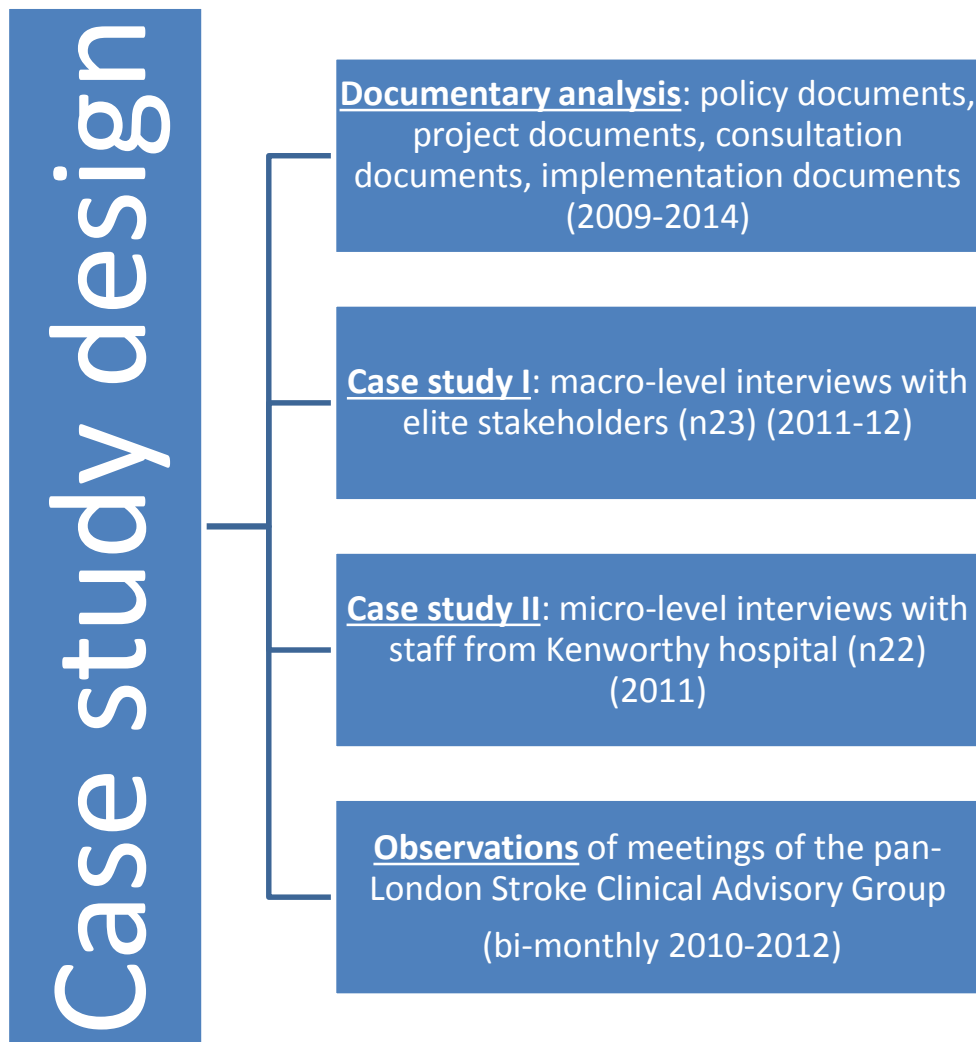


Figure 2, case study design

There was a gap between the timing of the key strategic decisions behind the reconfiguration (2008-09) and my PhD enrolment (2009-14). This had an impact on the selected methodology, as it meant that part of the study was approached historically as opposed to contemporaneously. This historical approach to the study of reconfigurations is quite common in the social science literature relating to health care reconfigurations and mergers (Fulop et al, 2005; Cameron et al, 2007; Choi and Brommels, 2009) and indeed there are advantages to this approach – a retrospective view on how and why processes developed as

they did is useful. Furthermore, by analysing public documents and combining these with retrospective semi-structured interviews with decision makers exploring drivers and objectives of change, it is possible to critically engage in the examination of ‘stated and unstated drivers’ behind change (Fulop et al, 2005). There are disadvantages too, and authors have argued that a longitudinal approach to reconfiguration studies is preferable (Spurgeon et al 2010). However, for practical reasons (due to when this PhD was commenced), I was not able to start my data collection before the stroke reconfiguration process began.

Qualitative research should aim for a richness or ‘thick description’ (Geertz, 1994; Walker, 1980) which lends qualitative work a level of transferability, or theoretical generalisation (Richie and Lewis, 2003). This concept of transferability ‘represents the extent to which findings of a particular study may be applied to similar contexts’ (Murphy and Dingwall, 1998; p195) and provides a useful way to approach the issue of ‘generalisability’ in qualitative research. There are myriad views on the extent to which case studies and qualitative findings overall can be generalised. Case studies have high internal validity but lower external validity (Denzin and Lincoln, 2011). It is often argued that case studies are useful for highlighting local causality, but not for the development of more general theoretical claims (Bowling, 2009). Miles and Huberman (1994) highlight the value of methods such as ‘looking for negative evidence’ and accounting for this in increasing the robustness of qualitative data, yet remain sceptical about generalising from single or small number case studies.

A counter view is offered by Flyvbjerg (2006), who lists five commonly cited ‘misunderstandings’ that critics of single or small number case study methodologies raise; (1)

that knowledge independent of context – i.e. that which is general, or theoretical is of greater worth than knowledge which is context-dependent and based on concrete, or practical experience; (2) that generalisation from single case studies is impossible – thereby inhibiting the contribution of case study methods to scientific development; (3) case studies are best suited to hypothesis generation rather than hypothesis testing; (4) that case studies predispose researchers to verification rather than falsification – and thus express an inherent bias; and (5) that it is hard to effectively summarise case study research, making theoretical development based on general propositions very difficult (Flyvbjerg, 2006; p3). He defends a case study approach from these ‘misunderstandings’ very effectively by rejecting the existence of (1) non-contextually mediated knowledge: ‘predictive theories and universals cannot be found in the study of human affairs. Concrete, context-dependent knowledge is therefore more valuable than the search for predictive theories and universals’ (Flyvbjerg, 2006; p7). Next he (2) argues that generalisation is overrated in scientific development, and that ‘the force of the example’ is frequently underestimated – citing Galileo’s rejection of Aristotle’s law of gravity as an example of this from the natural sciences so that generalisation from one case is indeed possible so long as the case is well selected and the methods used to conduct the case study are sufficiently rigorous. Intense observation of a small scale phenomenon may be more instructive than the use of large random samples. Thus different problems require different methods of analysis (Flyvbjerg, 2006; p10).

This in turn leads to the third point – (3) single or small number case studies can be used to test hypotheses if the researcher’s goal is *richness* of information; by selecting an atypical, or extreme case, the researcher may learn more about underlying processes, procedures and actions than selecting a series of representative or random samples, as the former may be more likely to illuminate the deeper causes of particular problems whilst the latter may

simply describe the symptoms and frequency of such respective problems (Flyvbjerg, 2006; p13). The fourth point is dealt with by listing studies by proponents of small-N research such as Geertz (1995) amongst others who had their initial theories challenged by conducting case studies suggesting that (4) when done diligently and reflexively case study research generates multiple compelling explanations which challenge and reframe early hypotheses – emphasising falsification over verification for researchers in many instances (Flyvbjerg, 2006; p21). With respect to the final point he concedes that (5) summarising case studies is difficult (less so outcomes); but that this difficulty is based more upon the reality studied than the method employed and that furthermore ‘good studies should be read as narratives in their entirety’ (Flyvbjerg, 2006; p25). Other authors also defend the robustness of single and small number case study methods. For example Mays and Pope (1995) argue that single case studies can demonstrate ‘features or categories relevant to a wide number of settings’ and are strongly compatible with examining processes within organisations (Pettigrew, 1997; Langley, 1999; Van de Ven and Poole, 2005). Likewise Tsoukas suggests that:

‘[E]xplanatory idiographic studies are epistemologically valid because they are concerned with the clarification of structures and their associated generative mechanisms, which have been contingently capable of producing the observed phenomena’ (Tsoukas, 1989)

Using a positivistic framework then, a single, or double case study design would be seen to be difficult to generalise from, and the design would therefore be a weakness, though from other more interpretive perspectives, the ability to dig down deeply into the contingent nature of organisational processes and broader themes (such as knowledge and power) is valuable.

Furthermore, as part of the data analysis stage of this work, it was possible to consider the application of the theoretical framework and analytical methodology to other published studies of reconfiguration to test the extent to which the approach was transferable following Mitchell (1983) and Bryman (1988), in the spirit of ‘analytic induction’ rather than ‘enumerative induction’ focusing on transferability or generalisation in terms of *theory* rather than population.

Having now explained the philosophical approach to the research and indicated the research design, the next section details how the research progressed in the field.

4.4 The research strategy

This section explains and justifies the methods used to collect, analyse and interpret the data presented in this thesis. Following the principles of triangulation (Mays and Pope, 1995; Yin, 2009), multiple methods of data collection were employed. These included 45 semi-structured interviews alongside documentary analysis and observations of meetings.

Interviews may allow the interviewer to explore how respondents define their own positions and views – sentiments which cannot be observed such as ‘feelings, thoughts, intentions’ (Patton 1980; p196) can be explored in this media. Documentary analysis aids an understanding of how organisations might wish to justify their positions and decisions at a corporate level – though as Atkinson and Coffey (1997; p128) advise, documentary data must be placed within their organisational settings and cultural contexts. Finally, observation may allow health researchers to study what occurs in the ‘black box’ (Murphy and Dingwall 1998) and allows us to analyse decision making in a way that reading about how decisions were

made, or discussing with decision makers how they arrived at policy decisions does not. Whilst recognizing that triangulation is not a panacea – it does not automatically grant validity to findings, indeed it may bring further problems for researchers (Silverman, 2010; Sim and Sharp, 1998) creating confusion rather than clarity, this research follows the principle that in broad terms: ‘People are complex and should be studied by watching them, joining in talking and reading what they write’ (Pope and Mays, 1995).

As with most qualitative research, the processes employed needed to be flexible (Marshall, 1996) at times as goals changed in response to unexpected findings in the field with positive and negative consequences. The following subsections will describe the work done as part of the thesis, how it was done, when, where, why and who with. It will describe how much data was generated, how it connects with the research question, how it was analysed, and also any problems encountered. This will be structured by data source– beginning then with interviews (2011-2012), followed by documentary analysis (2009-2014), and finally observations (2010-2012).

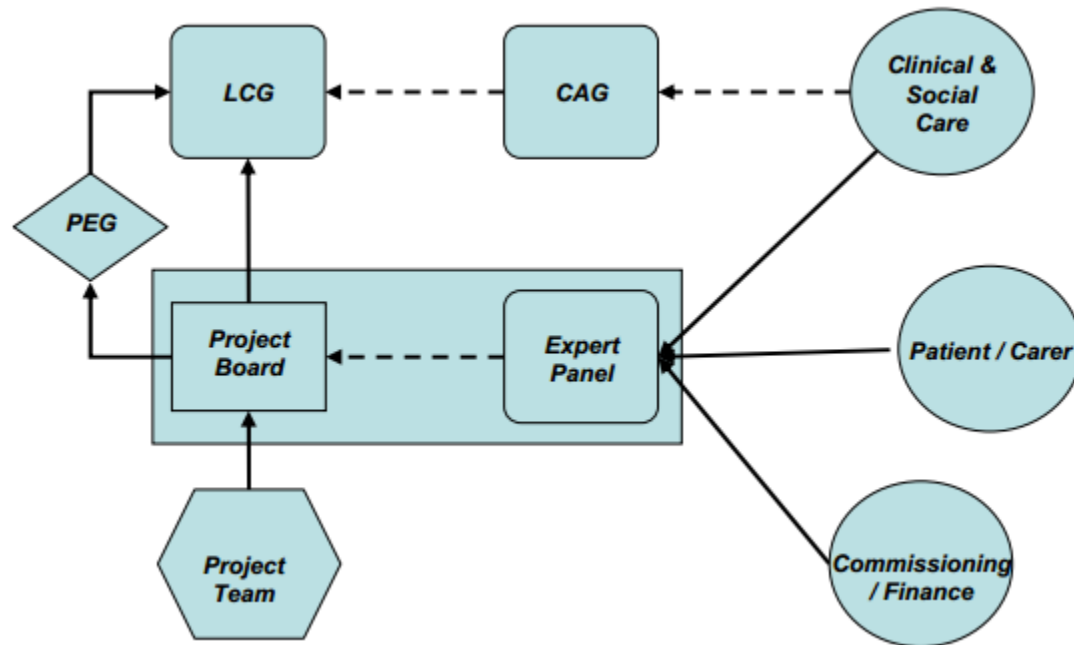
4.51 Interviews (2011-2012)

This section describes the rationale behind the choice to conduct 45 semi-structured interviews, the sampling and selection strategies employed; how these developed over time and how and why they deviated from the original research design. Then the data analysis strategy is described and reflected upon critically.

Britten (1995) suggests that the types of question which are well served by qualitative interview techniques relate to; behaviour or experience, opinion or belief, feelings, knowledge, sensory/perception and background or demography. The choice of semi-structured interviews was considered most appropriate because structured interviews with 'mostly fixed choice' responses would not allow a deep enough examination of the issues of interest for this thesis; for example, complex, potentially 'hidden' notions relating to power structures or the application of knowledge. Likewise, interviews that covered just one or two topics would have been inappropriate, as the research question encompassed a broad thematic interest in a number of issues, and just as structured interviews might be superficial, there would have been a danger that unstructured interviews might have become too focused upon minutiae which in turn may have mitigated against broader thematic analysis.

Hence the choice of the semi-structured interview as the most apposite method of primary data collection for this study – consisting of a loose structure with open ended questions that were designed thematically to extract the most relevant information from the respective informants. This interview data was supplemented with observational data and documentary data in an effort to 'triangulate' the findings and add greater contextual information and increase understanding of multi-organisational complexity (Mays and Pope, 1995).

Figure 3: Case study I: the macro-level (NHS London, 2008d) (the graphic is taken from, Appendix A of the Stroke Project Governance Arrangements, Oct 2008)



Key:

PEG: Programme Executive Group

LCG: London Commissioning Group

CAG: Clinical Advisory Group

Members of all the above groups with the exception of the patient/carer group and the PEG were interviewed – however I did interview both Project Managers with responsibility to report to the PEG. The first step was to conduct an informal interview with an NHS manager via a personal contact in November 2009 which was very useful in confirming a number of points around the potential interest in pursuing study into the reconfiguration. Further informal conversations with new colleagues on the EIS project at around the same period were also

useful in this regard. Informed by analysis of the NHS London documents in early 2010, an initial research design was instigated that focused on approaching members of the respective reconfiguration panels to be interviewed. These were, in order of importance; the central project board, the clinical expert panel, the finance and commissioning panel, the patient representative panel, and the JCPCT. Individuals on these boards were purposively selected (Murphy and Dingwall, 1998) because they were closely involved in key decisions around the design and implementation of the reformed stroke service. There was also an element of opportunity to these choices; because through professional EIS project contacts there was a good chance of securing interviews with certain members of these (first two) boards in particular.

And so it proved, interviews were secured with 8 members of the project board, 8 of the clinical expert panel and 5 of the commissioning and finance panel. Along with other informants identified through the pan-London Stroke CAG observations and case study II very good coverage of the key professional and managerial figures involved in the reconfiguration was achieved. The table of those interviewed as part of the macro-level study is presented below:

Table 5: Case Study I Informant list

| Job title | | Relevance/experience | Role |
|--|--|---|--------------|
| Stroke Nurse Specialist | | Clinical expert panel, project board and Stroke Clinical Advisory Group (permanent) | Professional |
| Clinical Director for Stroke in London (Doctor 1) | | Clinical expert panel, project board and Stroke Clinical Advisory Group (permanent) | Professional |

| | | |
|---|---|--------------|
| Stroke Consultant (Doctor 2) | Clinical expert panel, project board and Stroke Clinical Advisory Group (permanent) | Professional |
| Stroke Consultant (Doctor 3) | <i>Kenworthy</i> hospital and Clinical expert panel and Clinical Advisory Group | Professional |
| Public Health Expert (Doctor 4) | Clinical expert panel and Project Board | Professional |
| Specialist Registrar (stroke) (Doctor 6) | <i>Kenworthy</i> hospital | Professional |
| Medical Director for the Stroke Project (Doctor/Manager 1) | Project Board Chair (clinical), CEO of a London Hospital and Clinical expert panel | Professional |
| Ward Manager 2 and nurse | <i>Kenworthy</i> hospital | Professional |
| Clinical specialist physiotherapist in stroke (AHP 1) | Clinical expert panel | Professional |
| Assistant Medical Director | London Ambulance Service, Project Board | Professional |
| Stroke Network Director 1 | Finance and Commissioning Panel, Stroke Clinical Advisory Group (permanent) | Managerial |
| Assistant Stroke Network Director | Stroke Clinical Advisory Group (occasional) | Managerial |
| Stroke Network Director 2 | Project Board | Managerial |
| Stroke Network Director 3 | Finance and Commissioning Panel | Managerial |
| Network Project Lead (Network Project Manager 3) | Stroke Clinical Advisory Group (permanent) | Managerial |
| Senior SHA Manager (SHA Manager 1) | NHS London Senior manager | Managerial |

| | |
|--|---|
| Stroke Project Lead (SHA Manager 2) | Project Board Chair (managerial) and Managerial Commissioning and Finance Panel and CEO of a London PCT |
| Project Manager for stroke project | NHS London, Project Board Managerial |
| Clinical Services Manager for stroke | <i>Kenworthy</i> hospital and Clinical Advisory Managerial Group |
| Independent Management Consultant | Commissioned by <i>Kenworthy</i> hospital to Consultancy prepare HASU bid |
| Management Consultant Lead for Stroke Project | Project Board (Consulting Company)and Consultancy Clinical expert panel and Commissioning and Finance Panel |
| Charity Communications Director | Clinical expert panel and Stroke Clinical Charity Advisory Group (permanent) |
| Charity Director | Project Board Charity |

Unfortunately, none of those cited as patient/carers consented to be interviewed when approached. Whilst I did interview two representatives from stroke charities, I am aware that the lack of PPI interviews represents a limitation of the study. In mitigation, as important as the patient voice is to health services research, my primary analytical focus was on how managers and professionals interpret and use the discourse of evidence in shaping services and care for patients. I also failed to interview any of the members of the JCPCT despite multiple attempts to invite them to take part. I was disappointed about the reluctance of any of those I approached from the JCPCT to take part – however, I did manage to review the relevant meeting agenda items, minutes and supplementary papers of this important board. A

limitation of my research that I am aware of is however, is its inability to engage beyond this official account of the site selection meetings from the perspective of the JCPCT.

The interview schedule was piloted in early August 2011 with a London stroke consultant leading to some small amendments. Formal interviews began shortly after this in late August that year. The interview schedule was loosely based around the four strands of the Dean framework (2010), but included open ended questions about informants' experiences of the reconfiguration, permitting a 'responsive' interview technique (Rubin and Rubin, 2011) through which distinct topics and themes emerged and were pursued within each interview and also over the 16 months of the interviews. By the end of 2012 theoretical saturation point (Glaser and Strauss, 1967) had been reached with the macro-level data in that the interview data was generating no new empirical or conceptual information. A decision was then taken to cease the interview process.

Case study II: the micro-level

Alongside the analysis of macro-level pan-London change, it seemed important to learn more about how the reconfiguration affected staff delivering care at the micro-level, to discover how views of the reconfiguration might converge or diverge between elite level professionals and those tasked with delivering care. *Kenworthy* hospital was purposively sampled (Patton, 2002) as it was one of the eight new HASU sites in London and undergoing organisational change as part of the reconfiguration. Semi-structured interviews were carried out with the following staff between September-December 2011. The staff were purposively sampled to provide a wide range of professional and management perspectives on the

implementation of evidence based stroke care and the effectiveness of different tools in achieving this. Details of the staff interviewed are given below:

Table 6 Case study II informant list

| Job title | Relevance/experience | Role |
|---|-----------------------------|---------------|
| Stroke research nurse | <i>Kenworthy hospital</i> | Professional |
| HASU Coordinator (and nurse) | <i>Kenworthy hospital</i> | Professional |
| Staff nurse | <i>Kenworthy hospital</i> | Professional |
| Health Care Assistant | <i>Kenworthy hospital</i> | Professional |
| Stroke Consultant (Doctor 3) | <i>Kenworthy hospital</i> | Professional |
| Stroke consultant (Doctor 5) | <i>Kenworthy hospital</i> | Professional |
| Specialist Registrar (stroke) (Doctor 6) | <i>Kenworthy hospital</i> | Professional |
| Consultant Radiologist | <i>Kenworthy hospital</i> | Professional |
| General Practitioner | Regional PCT | Professional |
| Occupational Therapist (I/P) | <i>Kenworthy hospital</i> | Professional |
| Speech and Language Therapist (I/P) | <i>Kenworthy hospital</i> | Professional |
| Dietician | <i>Kenworthy hospital</i> | Professional |
| Occupational Therapist (Community) | <i>Kenworthy hospital</i> | Professional |
| Psychologist | <i>Kenworthy hospital</i> | Professional |
| Physiotherapist (I/P) | <i>Kenworthy hospital</i> | Professional |
| Occupational Therapies Lead | <i>Kenworthy hospital</i> | Professional |
| Stroke care coordinator (community) | <i>Kenworthy hospital</i> | Administrator |
| Ward manager 1 (and nurse) | <i>Kenworthy hospital</i> | Managerial |
| Ward manager 2 (and nurse) | <i>Kenworthy hospital</i> | Managerial |
| Clinical Services Manager | <i>Kenworthy hospital</i> | Managerial |

| | | |
|--|---------------------------|------------|
| Matron (Care of the elderly including stroke) | <i>Kenworthy</i> hospital | Managerial |
| Director of stroke and care of the elderly services | <i>Kenworthy</i> hospital | Managerial |

The original research plan for the PhD data collection had been to interview the *Kenworthy* staff once using the EIS designed interview schedule (see appendix G), and through these interviews identify key figures and invite them to a second interview using the PhD interview schedule (see appendix F). In December 2011, whilst following this plan, very quickly some unanticipated problems were identified with this approach alongside a realisation that there was the potential to exploit a rich data source that had not been considered for the PhD previously.

Firstly, following the original plan of re-interviewing EIS informants at *Kenworthy* for the PhD, two members of staff were interviewed for the second time and we found it was not a good use of our collective time to ‘rehash’ ground we had already covered in the EIS interview. However information which emerged from the initial EIS interview had been drawn on in both subsequent interviews. This allowed questions to be targeted and framed in ways that allowed a deeper exploration into specific areas. However, if in the analysis of the interviews, the contextual information gained in the first interview (for the EIS project) and other interviews with other *Kenworthy* staff was not drawn upon, then the information gleaned from the PhD interview felt less ‘whole’. This was a clear impression which emerged from early reflections and attempts to analyse and think about themes from these interviews. In order to avoid this there were two options: (a) use the first (EIS) interviews too in my

(PhD) analysis or (b) go over the same ground for the sake of verifiable completeness. The latter would have been time consuming and tiresome for both the informant and interviewer.

Furthermore, reflecting upon the analysis of my early (macro-level) PhD interviews new similarities in emergent themes in both the EIS and PhD data were noted. In the EIS interviews the focus was on evidence based practice and how it has been implemented – all *Kenworthy* respondents spontaneously referred to the London reconfiguration as this had been a major driver in these processes. In the PhD interviews, the focus was on the London reconfiguration and how the changes it has heralded have been implemented - all respondents spontaneously referred to policy and management instruments/implementation methods used to make practice more evidence based.

These findings were discussed with my supervisors and a decision to use the data from the interviews performed at *Kenworthy* as part of my PhD analysis was made. These were supplemented by some interviews with staff who were missed as part of the EIS work (they were unavailable to be interviewed when I was at the hospital in the Autumn but were willing to be interviewed in the Winter), and a small number of specifically focused further interviews with particularly important informants identified via the EIS interviews and CAG observations as being worthy of interviewing further for the PhD. These final interviews were conducted at *Kenworthy* in December 2011, reaching saturation point shortly before Christmas that year once no new relevant data was felt to be emerging from the micro-level interviews (Glaser and Strauss, 1967).

Nevertheless, this decision had some ethical and methodological implications which needed to be addressed. Firstly, ethics; an exemption from the need for formal NHS ethics from GSTT in May, 2010 and KCL ethical clearance in June 2010 had been achieved (see copies of ethics/R&D letters and documentation in the appendix of the thesis) – but as part of this arrangement, it was agreed that the work would require local Research and Development clearance from each Trust or Commissioning group whose staff members were interviewed or observed. Given that now, data collected for the EIS project at *Kenworthy* was also to be used for the PhD work, the advice of the KCL governance board was sought around issues of consent. The advice received was to contact each informant, explain the situation and ask for retrospective clearance to use their EIS data for the PhD project – which was subsequently done.

Methodologically, it made sense to recode the *Kenworthy* data that had been generated through the EIS interview schedule using the same process developed for the macro-level PhD data analysis – therefore keeping two separate data bases in Nvivo (QSR International, 2009) – the data for the EIS project being analysed more inductively and collaboratively with my research team; whilst the data for the PhD were analysed using a more deductive approach based on Dean's analytics of government and done so independently – this approach is discussed in greater detail below.

Overall, 45 semi-structured interviews were conducted with 41 different individuals across the macro-level and micro-level studies. The interviews generally lasted about 60-70 minutes, and all but one was done face-to-face (one being done over the telephone). Handwritten notes were taken during the interviews to aid memory of real-time perceptions and interpretation.

For most interviews these notes were then typed up shortly following the interview for a number of reasons; firstly, to aid critical reflection on the progress of the interview and underline the key themes that seemed important at the time, secondly to aid reflection on the significance of the interview compared to other recent data analyses as a form of ‘constant comparison’ (Glaser and Strauss, 1967) as often a number of days or even weeks might elapse before receiving the transcribed documents, and due to other work commitments there may have been delays before it was possible to begin formally coding the data. Thirdly, this process aided reflection on aspects of the interview schedule – leading to future improvements – for example, the questions related to ‘identity’ were often difficult to phrase adequately or express – reflecting on the interviews immediately after them helped to address this over time. Finally, immediate typing of the key points of the interview acted as a kind of safety net should any digital data be lost (thankfully this did not occur).

Most interviews generated about 10,000 words. The interviews were digitally audio-recorded following consent being sought from each informant. The audio files were sent electronically to a professional transcriber, transcribed and returned by email. The transcribed MS Word documents were then anonymised and uploaded to Nvivo 8 software. The two macro-level and micro-level files were analysed separately so that distinctions between the two datasets might be discernible, but the analytical technique and processes were the same.

The Research Question focuses on evidence, so analytically, the challenge was to deconstruct the different ways in which ‘evidence’ impacted upon the London stroke reforms. This was achieved by allotting primary codes along the four broad deductive ‘lines’ of the analytics of government (Dean, 2010) framework;

- *visibility*
- *techne*
- *episteme*
- *identity*

The interview data analysis also generated numerous other inductive themes. These secondary codes could be functional (e.g. *audit and standards, measurement, acute, rehab, professional relations*) or theoretical (e.g. *conflict, specialisation, medical dominance, biopolitics, soft power*). This allowed the data to be organised in a logical, manageable fashion, and highlight the relevant significant text from each of the different interviews. The next process was to print out primary and secondary coded data from Nvivo and review the different textual strands thematically – developing tertiary themes and conceptual points – for example, EBHC as a disciplinary power and/or as a form of governmentality (this then developed further following reading the Martin et al (2013) paper focused on similar themes) and the paradox of freedom/control and discipline/desire – again, influenced by the wider literature – for example Foucault’s later histories of sexuality and theories of technologies of the self (Foucault, 1986) and Starkey and McKinlay’s (1998) exploration of these themes in an organisational context.

The process then centred on building these fragments into a larger theory – going between the data and the wider literature iteratively and exploring deviant cases – for example, a key finding was the compatibility of managerial and professional goals and techniques of power in reforming stroke care which is evident throughout the reconfiguration process with a major exception linked to the selection of HASU sites – this phenomenon was therefore explored in detail and the reasons for the conflict were identified and discussed (Pope and Mays, 1995). The ‘ethical’ and ‘economic’ rationales linking the mutual compatibility of managerial and

professional goals became apparent through this process of breaking the data down then building it up again by a process of ‘de-contextualisation’ then ‘re-contextualisation’ (Tesch, 1990) by exploring themes and extracting them from one data source and building it up alongside another. In this way the results began to take shape thematically as dominant findings emerged from the case study I and II data sets, triangulated with observation and documentary source data. These results were written up and different schemas were trialled to identify the best way to present the data. This was however, a long and iterative process.

Some of the interview data were incorporated easily into one broad ‘line’ of the analytics of government, but much of it cut across two or more of the four ‘lines’. The importance of the *episteme* and *techne* codes and the ways in which these spread into other codes was significant in aiding conceptual development with regard to the ‘non-subjective intentionality’ (Dean, 2010) of the reforms. It took a long time to develop this insight however – for a long time a key concern was to explore the four strands of the framework (almost) independently. Indeed other scholars have taken such an approach when drawing on the work of Dean – for example Winch and Creedy (2002) in a health care (evidence based nursing) context.

It felt deceptively attractive to structure the results around the four analytical lines of the analytics of government framework (an early idea was to produce four distinct chapters in this way and indeed numerous drafts in this form were produced) but each time, the work felt rather flat when structured in this way. It became more apparent through this phase of trial and error result writing that whilst it is relatively easy to show ‘lines of visibility’ for example across certain aspects of the data –these ‘lines’ are contextually illuminating only when

considered in tandem with epistemic, technical and identity ‘lines’. The analysis developed a major focus on epistemic operationalisation – or how evidence may be understood in different ways and having different functions. To illustrate this: as a primary code *episteme* cut across many areas and reflected a circularity found in EBHC as a power/knowledge nexus (Shaw and Greenhalgh, 2008; Ferlie et al, 2011). So, by *episteme*, the analysis explores evidence *of* practice – i.e. qualitative and quantitative data related to actual practice – this data makes current practice *visible* and can be used as a *technique* of control of/by/for managers and professionals which in turn impacts upon their respective *identities*. Likewise, evidence *for* practice – i.e. guidelines, research papers, policy directives – makes best or chosen practice *visible*, is useful as a *technique* guide professionals and enable changes of practice (in either disciplinary or desire terms) and also impacts upon the subjectivities of individuals and their respective *identity* work.

Thus, the process of data analysis of the interview data was a long one – especially when incorporating the observational and documentary data. It was important to reflect back on the points of similarities and difference between the three data sources and explore how these supported or challenged the emergent interpretations across the whole data set. In this way the structure of the analytics of government was an advantage as an heuristic device in that the data sources were coded across the four strands of the analytics, which made triangulation (whilst not problematic) certainly manageable. Paradoxically however, managing to ‘go beyond the data’ and generate any kind of significant ‘conceptual leap’ (Klag and Langley, 2013) only occurred once I ceased thinking about the data in such a controlled and structured manner by really focusing on the ‘non-subjective intentionality’ (Dean, 2010) of the stroke reform programme in London and how the four strands interact within different contexts.

4.52 Documents (2009-2014)

There are four distinct types and sources of documents that have been integral to this PhD. They have been handled in different ways – reflecting contrasting strategies at different times of the research process. These include official London health care reviews carried out by various expert panels since 1992; official documentation produced by the Health care for London team as part of, or alongside the (preliminary and final) stroke strategy for London reports of 2008; and finally, documents focused on the decision-making process of the JCPCT and JHOSC in giving the green light to the stroke (and trauma) reconfiguration plans in 2009; documentation produced in support of LMDS and SINAP audits and other documents focused on data measurement and implementation – provided via the meetings’ observations and through discussions and through work at *Kenworthy* hospital. These will be discussed in turn.

The first significant documentary resource that the thesis draws upon is official policy documentation focused on three high profile reviews of London health care since 1992. A formal content analysis (Bowling, 2009) of these documents was performed (and is presented in section 5.2). Details of the documents are given below:

Table 7: London Health Care Reviews

| Year | Title | Publication details |
|------|---|----------------------|
| 1992 | <i>Tomlinson Report</i> | HMSO |
| 1997 | <i>Turnberg Review</i> | Department of Health |
| 2007 | <i>Health care for London: A framework for Action</i> | NHS London |

Having studied the large quantity of documentation produced as part of the reconfiguration programme (some aimed at the public, some at practitioners) as part of the early work of the PhD – in effect, becoming acquainted with the field a decision was made to focus on how the policy Discourse around evidence based health care had developed in key official policy texts relating specifically to the needs of London. These three texts were selected for three reasons. Firstly, they focus on London health care and how this has been problematised (Dean, 2010) and point to an evolving strategy around framing problems and presenting solutions for different political administrations (the Major government, 1992; early New Labour, 1997; and late New Labour, 2007) they therefore might shed light on NPM, post-NPM and network governance influenced policy making. Secondly, if a choice is made to locate the effective ‘birth’ of EBM with Sackett and colleagues’ (1996) *BMJ* articles, then there is one review which pre-dates this (Tomlinson), another which is almost contemporaneous (Turnberg) and a third which is carried out a decade later (Darzi) – so this might shed some light on the permeation of ‘evidence based’ health care and policy making and its respective importance for professionals, managers, policy makers and the public. Thirdly, the years 1992-2007 represent a significant time in the development of stroke care in both policy and research terms – with advances in the evidence base behind the effectiveness of thrombolysis for stroke patients (NINDS, 1995) and stroke unit care (SUTC, 2007), so reviews over this period are of practical interest.

Official policy documents are useful for analysis because they seek to influence views, beliefs and actions (Martin and Learmonth, 2012; p283). However, it is clear that there is more than one way of interpreting these documents and that my findings are necessarily subjective. For this reason it is important to be clear about the systematic methods by which the documents were analysed. I conducted a series of textual key word searches using the following key terms:

- *Evidence; evidence based; evidence-based*
- *Stroke*
- *Close; closure; merge; merger*
- *Reconfigure; reconfiguration*

These terms were selected to reflect the focus of the research question around the evidence and motivation behind the stroke service reconfiguration. Multiple readings of the texts focused on how ‘evidence’ was framed and interpreted were conducted, and how stroke was considered (if at all). The primary aim was to explore what motivates change – for example, economic drivers and/or service ‘quality’. A secondary aim was to understand more about the potential progress of an ‘evidence based’ Discourse (both in general and stroke specific terms) developing in regional health care policy making across different political administrations. There was also an interest in presentational development – how did the different texts present their findings (graphs, tables, photos, referencing style) and what different types of stakeholders were invited to contribute; also who were the authors and who was the apparent audience? This approach was influenced by the Appleby et al (2011) King’s Fund Report which highlighted the development of London health care ‘problematisations’

and accordant reviews. Methodologically, it takes a similar approach to that of Martin and Learmonth (2012) and their analysis of the discourses of administration, leadership and management (2012; p283). This systematic approach was useful for these formal policy documents because it allowed a comparative study of policy discourse progression over time. There are some potential limitations to this approach. Bowling (2009) for example suggests that content analysis ought to have two coders to limit the subjective nature of the process; that content analysis merely tests the ability of the researcher to enforce their own theoretical biases (Bowling, 2009); and finally counting the frequencies of a phenomenon decontextualizes its meaning. In response to these criticisms, firstly, it must be conceded that there is an inherent subjective element to content analysis (and indeed all interpretive qualitative research), but that through discussion with my supervisors, and a reflexive approach this is consciously acknowledged (additionally it is the case that double coding would be inappropriate for individual PhD study). Second, the chosen theoretical approach, drawing on Dean's (2010) framework is very clear about the four dimensions that structure the study – here focusing in particular on fields of visibility and epistemic development in official policy review documentation. Finally, to counter the third complaint, the analysis endeavoured to go beyond a mere tally of relevant words and present the findings within a broader context to enrich an understanding of the significance of the findings.

This section now discusses the other three types of documentary data drawn upon for the thesis. These were not formally analysed as the Tomlinson, Turnberg and Darzi reports just discussed because they were used more as a background resource rather than as a key analytic resource. Nevertheless, these documents were all significant to the work of the thesis in their own specific ways as explained below.

Since early 2010, shortly after the commencement of the PhD, all the available documents published on the NHS London website connected to the stroke reconfiguration have been systematically downloaded. 91 documents were downloaded and read as part of this process – detailed notes were made on these papers. Much of the documentation relating to the stroke reconfiguration from the Health care for London website was produced in support of the work led by the project team around the development of the proposed stroke strategy for London – many being technical appendices. The strategy documents themselves - there were two – *preliminary* (NHS London June, 2008) and *final* (NHS London November 2008)- were particularly useful in guiding my understanding around how stroke was problematised, how evidence was seen as central to this and the technical challenge and project management tools that would be used to guide the reconfiguration.

These documents provided me with a good initial understanding of the strategic approach of the project team to managing the various aspects of the reconfiguration. They were aimed at both a public audience keen for greater detail than appears in the strategy booklets, and also at providers and commissioners – for example there is voluminous information for providers around how to bid for HASU, SU and TIA status alongside overviews of commissioning and finance arrangements. Following consideration of the potential advantages and disadvantages, a decision not to formally code these documents or download them into Nvivo was made. The reason for this decision was that many of these documents were technical appendices of limited value to detailed content analysis - rather they were best utilised as a background resource to firstly inform the development of the interview schedule and secondly to triangulate (Yin, 2009) with specific emerging themes from the observations and

interviews. These technical appendices were used strategically to bolster awareness of specific issues and as a counter-resource to other data, rather than using all the documents systematically. For example, they were very useful to return to when considering the importance of the ‘site selection’ issue (see chapter VI section 1) which emerged through interviews with senior clinical and managerial stakeholders as part of case study I.

This same interest in the selection of HASU sites led to the third documentary source to be discussed here. 31 PDF files relating to the decision making of the JCPCT in the key January and July meetings in 2009 where the site selection decision was made, including minutes, agenda items, presentations and various annexes were analysed. These documents discussed the project management strategy, public consultation and JHOSC processes from the JCPCT point of view. Analysis of these documents proved invaluable as they articulate the official ‘story’ of how a number of key decisions were made – they show that the recommendations of the project board were followed by the JCPCT, and the importance placed by the team on presenting the reforms as ‘evidence based’ with full ‘clinician support’ and strategies to manage the public consultation. These data provided an important resource for comparison in concert with the interview data generated around these topics – especially given the difficulties encountered in engaging members of the JCPCT to be interviewed. Again, as with the NHS London documentation, a decision was made not to systematically code these documents as this was deemed to be of limited value – their key utility lay in strategic illumination of specific issues.

The final documentary resource included papers and guidelines which emerged from the observational work, interviews and informal discussions at *Kenworthy* hospital. These

centred mostly around the London Minimum Data Set (LMDS) and SINAP data requirements and auditing tools and are discussed in chapter VI section 3 and chapter VII section 3. These documents show the priorities which the commissioners and networks in conjunction with the project team, and then the pan-London Clinical Advisory Group used to measure implementation and fidelity with the new regimes of practice (Dean, 2010). The differences in focus between organisational and clinical standards and inter-professional distinctions are useful here. Again, these technical documents were not applicable for systematic coding but were rather used to guide informal discussions and formal interviews with key informants, as well as a tool to juxtapose gaps between official goals and the interpretations of those who used them. Other key stroke focused national publications and documents generated by the DH, RCP, NICE, the NAO and other bodies have been analysed to inform the broader knowledge base around the specific London reforms and are referred to throughout the body of the thesis where appropriate. The next key data source to be discussed is observational data.

4.53 Observations (2010-2012)

The third and final key data source that the thesis draws upon is observations of the pan-London Stroke Clinical Advisory Group (CAG) meetings conducted over a two year period. From September 2010 to September 2012 I attended each two hour bi-monthly CAG meeting as a non-participant observer. I also attended an 8 site HASU meeting in July 2011, and a local network meeting at a London hospital also in 2011. As part of my early research into the stroke reconfiguration process and immersion in the documents described in the previous section in early 2010 I began to develop an interest in the work of the five sector specific stroke networks. Through a link on one of the networks' websites I sent a rather speculative

email asking a number of questions about the work of the stroke networks in London. My email was passed on to a senior project manager for one of the stroke networks. This project manager was extremely helpful and after some email correspondence we met for an informal talk in Summer 2010. She provided the key administrative support to the CAG and suggested that it might be useful for my PhD to observe the work of the CAG. This was agreed by her line manager (the Network Director) as managerial lead for the CAG and by the Clinical Director for Stroke for the city (as clinical lead for the CAG).

Although I had already secured an exemption from the need for formal NHS ethics clearance via GSTT and KCL ethics clearance in May 2010, I needed to secure local governance approval from the trust of each of the informants I spoke to – this was a rather time consuming process as they came from across the 31 different PCTs plus further acute trusts – each with separate local governance arrangements. To compound this, the CAG was governed by a particular PCT which was not used to requests such as mine, plus it was undergoing structural reform as part of the new coalition government's reforms. Eventually I was granted retrospective clearance to use data from the CAG meetings I had attended – thanks in a large part to the support of the senior project manager and the managerial and clinical leads for the CAG who wrote in support of my request.

At the start of each meeting, all the participants introduced themselves – including me, and I stated that I was doing a PhD study into the reconfiguration. It was made clear by the Chair that if anyone had any objections to my presence – then it would be fine to raise them. However, nobody ever did – in fact most people (when chatting informally before or after the meetings) could not understand why I wanted to sit through such long meetings when I did

not have to. I was very careful to say nothing in the meetings, but I was included in the email distribution list for the two years I observed the meetings (after the round table introductions), and offered copies of the documents discussed (Appendices H and I show a draft of one of the minutes of the meetings and also an agenda).

The meetings were peripatetic and held in different network buildings across the capital. They generally lasted just over two hours. There were usually between 10-20 attendees. The meetings were chaired by the clinical director for stroke (deputised for by another consultant when he was not there). A network director sat alongside the clinical director – she was an important member of the group – offering a management view; reflecting the commissioners' viewpoint around the topics of discussion – often she would be joined by network directors or assistant directors from other London regions. In addition to this there were usually about five other HASU lead consultants, a stroke nurse specialist (also clinical lead for her SU) and other nursing and therapies representation – both in-patient and community. There was a senior London Ambulance Service representative who spoke very often with respect to issues around ambulance care. There was frequent attendance by a stroke charity representative – he provided an insight into some of the public relations' impacts that policies might have – alongside the network director – the professionals often deferred to their knowledge here. There was no GP representative (contrary to the mandate published in the NHS London documentation around the need for this). A consistent theme discussed by the panel was the need for more attendees from Stroke Units (as opposed to Hyper Acute Stroke Units), nurses, and rehabilitation experts (both in-patient and even more so community base), and discussions around strategies to reach put to these individuals and communities. Over the two years of observations, this did appear to be slowly addressed – especially as rehabilitation issues became more significant, as the HASU and SU pathways became more embedded over

time. Administrative support and in depth knowledge around many of the data collection issues was provided by the senior project manager. Senior medical voices tended to dominate the discussions, but challenges to this were respectfully received. There was a good gender balance across the group. Often, outside speakers were invited to present on certain topics – these would often be data presentations reflecting progress or problems with the new model – other-times contingency plans – for example, there was an interesting presentation on the potential impact that the Olympic Games in 2012 might have on the functioning of the model.

My motivation for attending the meetings was firstly; to learn more about the ways in which different stakeholders interacted with each other in a pan-London setting – I felt this was important to do given that much of my focus was on historical data and actions – observing how different professionals and managers interacted contemporaneously was useful in triangulating with documentary and interview data. Secondly, I wanted to inductively learn more about the issues that the nascent implementation process was creating and how the participants responded to them. Thirdly, I wanted to analyse these interactions and emerging issues and themes, and through longitudinal and iterative engagement with Dean's analytics of government (1999) framework, develop theory deductively.

I chose not to analyse this data in Nvivo for a number of reasons. Firstly, the amount of data itself was relatively small and conducive to reading and re-reading in paper format. Secondly, given the delays in securing ethical clearance to use the data and the potential that I would not be able to use the data at all, my approach was to be reasonably pragmatic, and use the observational data as a triangulatory resource behind the documentary and interview data. My approach to the thesis was not primarily ethnographic- it could never be, as a large focus of

the PhD was essentially retrospective – but analysis of this data was highly valuable in illuminating a number of key themes which are discussed in detail (chapter VI section 2).

Certain key themes around control of clinical practices; firmness around standardising procedures and collecting data to show processes were working to prove the viability of the London model within a potentially hostile economic environment emerged consistently from the data collected and analysed. The group also functioned on an informal level – as well as the agenda items, they would often discuss non-minuted issues, often related to repatriation from a HASU to an SU, or examples of patients not being sent to HASUs where the protocol would suggest they ought to have been. Other examples of informal parts of the meeting were when the lead would provide information about meetings he had had with senior politicians, or commissioners, or the progress of studies commissioned to highlight the clinical and or economic effectiveness of the model. So, rather than use the observational data as a primary, detailed resource from which I draw many vignettes and examples in the thesis, I used the data more as a triangulation tool to inform my detailed analysis of the interview data – both thematically and conceptually.

A clear advantage of conducting the observations was that it gave me informal access to all the members of the CAG – almost all of whom were interviewed as part of case study I. It also meant that when interviewing them, I had a prior understanding of them and has ‘seen them in action’ in the meetings, and could discuss particular pertinent points. In particular, I developed a good relationship with the clinical and managerial leads from *Kenworthy* hospital via the meetings – I normally sat alongside the clinical services manager and we would chat before and after. Spending this time with these individuals over the two years was

extremely valuable, as I was able to gain a greater understanding of how they presented their domestic issues at a pan-London level, and how their closeness with the pan-London CAG was used (in particular by this manager) back at *Kenworthy*. It also meant that I could understand both macro-level (case study I) and micro-level (case study II) issues in greater context in particular with regard to the identity strand of the analytics of government framework.

I have frequently reflected on how my presence at the meetings may have elicited some kind of Hawthorne effect (Mayo, 2014) on the participants. I tried to minimise this by being as unobtrusive as possible, and through becoming a regular face at the meetings, hopefully I blended into the background. Of course it is possible that certain topics or discussions were avoided in my presence – in the same way that some points were not included in the official minutes. There are three further points to make here however. Firstly, the meeting minutes were to be made publicly available – these were not strictly private meetings. Secondly, I attended other meetings with some of the participants on numerous occasions (as a participant) and noted no different approach, manner or style which points towards a level of consistency, and thirdly, an overriding sense I took from the observations was the almost evangelical zeal that many of the participants had for the stroke reform project, and an appreciation for anyone who shared an interest in this and a desire to ensure that the project succeeded. So, whilst my presence may have had some effect on the participants and how they might compose themselves, as far as possible, I am confident this was not so great as to significantly devalue the reliability of my data.

I ceased attending the meetings in September 2012 because analysis of the data suggested I had reached saturation point (Glaser and Strauss, 1967) with respect to interaction, thematic and conceptual data after two years of regular attendance at the meetings. I was invited to attend a further meeting in December 2012 to feed back some perceptions to the group which I was happy to do – focusing mainly on my genuinely positive findings about their professionalism and dedication and group efficiency as opposed to my theoretical development about inter-professional and management-professional relations and development of systems of control through the reified stroke episteme, as I felt the former was both more readily comprehensible and practically relevant to the audience through a ten minute presentation.

4.6 Summary

This chapter placed the study in its epistemological context and justified the selected methodology. It demonstrated the coherence between the key research question and the theoretical approach to collecting and interpreting the data. The research described was discussed and its strengths and limitations were discussed. Finally, the three main data collection strategies were reflexively described and the analytical process was explained in order to provide the reader with an understanding of how the results which follow in the next three chapters were constructed.

Chapter V

The problematisation of stroke services in London

5.1 Introduction

The first empirical chapter of this thesis explores how London stroke services were identified as problematic during New Labour's third term. Using a governmentality approach (Foucault, 2007) an 'Analytics of Government' (Dean, 2010) is conducted to examine the forms of knowledge, evidence and governmental techniques which were used to construct specific issues related to stroke care as 'problems.' The chapter will commence by drawing on documentary analysis of the Tomlinson (1992), Turnberg (1997) and Darzi (2007) reviews into London health care to demonstrate the evolving impacts of Evidence Based Health Care (EBHC) in influencing the episteme through which strategic level decision making in health care may be seen to develop. These three high profile reports focused on London health care services offer a useful method to examine the 'fields of visibility of government' (Dean, 2010, p41) over health care in London and how they shifted over 15 years of policy making. Through these documents the chapter will explore the ways in which language, data presentation and political assumptions developed as evidence, specialist knowledge and clinical legitimacy became more important to strategic health care policy making. Interview data with those involved in the Darzi inspired reconfiguration will also be drawn on to

explore how management and governance techniques were selected and employed as part of this process.

The construction of stroke care as a ‘pan-London’ issue for the first time will be introduced and the professional and managerial aspects behind the traditional problems of high quality stroke care delivery will be discussed. The development of measurement programmes to chart and shape improvement initiatives and explicate traditional weaknesses and how this contributed to a powerful new episteme for stroke care is then discussed. The chapter explores the interprofessional aspects that emerged from the development of the specific London stroke care episteme and then critiques how the consensus for change was made and questions the strength of the evidence behind what was to become the ‘London stroke model’.

5.2 Section 1: Framing the problem

The Tomlinson Review was published in 1992. Bernard Tomlinson was a retired pathologist and Chairman of the Northern Regional Health Authority when commissioned by William Waldegrave to inquire into ‘London’s health service, medical education and research’. His report followed a King’s Fund Report in 1991 which concluded that 5,000 beds should be closed in the capital, there were too many doctors employed, overall costs were too high and that NHS care in London was particularly inefficient (cited in: Appleby et al, 2011) The review contains 5 simple tables of data and two maps, but the majority of the report is in black and white text. There are no illustrations, photos, or illustrative quotes from the ‘over 1,000 individuals’ the team spoke to. The word ‘evidence’ appears eight times in the 28,000

word text. The phrases ‘evidence based’ or ‘evidence-based’ do not appear at all reflecting the fact that the evidence based movement in health care was yet to establish itself in policy discourse. The word ‘stroke’ appears only once in the text and is described a ‘chronic’ condition (p9). A key passage of the text is cited below:

‘A number of inner London hospitals are already in financial difficulty as their high overheads, and the mismatch of the scale and nature of their services to current demand, place them at a disadvantage in the reformed NHS. It is essential that work be put in hand now to plan for a more appropriate level of capacity, and to rationalise the many dispersed specialist services. Closures and mergers will be necessary.’

Reference 1; Tomlinson Report (1992; p6)

The report emphasises economic rationalisation rather than clinical excellence. Frank Dobson commissioned Leslie Turnberg to review London health services in 1997. Turnberg had just retired as head of the Royal College of Physicians, and again, like Tomlinson, was expected to be independent of London health care politics. The presentation of his review consisted predominantly of written text, although it did include 3 maps, 3 graphs and 3 tables. The word ‘evidence’ appears 42 times and ‘evidence-based practice’ also makes an appearance – suggesting a shift in the importance of the Discourse of evidence in health care politics through the 1990s. The word ‘stroke’ does not appear in the main body of the text – however the ‘Stroke Association’ is credited as a contributor to the report under ‘Other Organisations and Associations’ in the final appendix. Over 200 organisations were invited to submit written evidence alongside a ‘programme of meetings and visits’. Over 1,500 letters were

received from the public. The authors rejected the notion that London has too many beds; however they were clear that the makeup of acute services in the capital needed to change:

‘We have spent much time assessing a number of specific plans for rationalisation of hospital services and have made what we hope will be helpful proposals. We realise that such difficult and usually controversial issues evoke strong reactions. We believe however that our proposals are realistic and rational given the circumstances which we discovered.’

Reference 2; Turnberg Report (1997; p.i)

The words ‘closure’ and ‘merger’ are used repeatedly through the text – often in the context of countering many of the plans drawn up in the Tomlinson Report. The seeds of what would become NHS London are planted here – in a call for a stronger strategic force to coordinate care in the capital - along with a commitment to the establishment of more accurate data capture and management systems:

‘The sheer quantity of information available is overwhelming and information management systems are urgently required. We recommend further work on the institution of accurate information systems which will provide relevant data about problems and needs and ways in which these are being met locally and for Londoners as a whole. Any good planning system will be dependent on reliable information.’

Reference 3; Turnberg Report (1997; p26)

This emphasis on information and data became central to New Labour policy making. This is emphasised in the Darzi review. The Darzi London review – *Health care for London, a framework for Action* was commissioned by David Nicholson as Chief Executive of the London SHA in Autumn 2006 and was published in July 2007. A key factor to note is that whilst Tomlinson and Turnberg respectively had been selected as ‘independent’ non-London based retired and supposedly objective arbiters of change; Darzi, as an eminent practicing surgeon and academic based at Imperial was quite clearly not. That was a strategic decision explained below in an interview with a senior NHS London manager:

‘London has a history of failed strategies... So my thinking about it was to look at, not in a terribly academic way, but just to try and think about why have all these previous attempts failed? And to try to counteract some of those. So, first of all, it was important to have somebody with a degree of knowledge, clinical knowledge to set out, you know, what’s wrong with what we’re doing now. So what had happened in the past, somebody from somewhere else has come, done a big report, gone off, lobbed it over the wall, right? So is it any wonder that then it doesn’t get [implemented] – so this was the Health care For London, as a study, or as a review was done by a practicing clinician, international repute, working in London... And he recruited, with our support, 250 clinicians to work with him. So there was a degree of authority to what he had to say, that I don’t think was present in previous reviews.’

Reference 4; SHA Manager 1

This manager presents the decision made by the SHA to ask Professor Darzi to lead the review as a practicing London clinician as a strategic choice to learn from many years of failed London reforms that had tended to lead to ‘conflict without change’ (Smith, 1982). The Darzi review was unlike its predecessors in the amount of support garnered from health care professionals. The report involved senior London medical leaders *subjecting* themselves and their colleagues to scrutiny rather than being ‘objectively’ scrutinised by an eminent outside observer. This produced collective ownership of both clinical problems and strategic solutions:

‘[Darzi] tried to assimilate clinical evidence both from this country and abroad to try to broaden the evidence base of what he was doing... I think [the Darzi report had] a degree of authority that others didn’t have, a degree of ownership from the clinical community within London that others didn’t have. And a commitment from me and the leadership team here to follow it through into implementation.’

Reference 5; SHA Manager 1

Darzi’s work on London therefore had clinical credibility and ownership amongst London health care leaders and the commitment of the SHA. There is an attention to aesthetic presentation to his report which contrasts profoundly with the work of Tomlinson and Turnberg. Physically, the Darzi report is brightly coloured, glossy, full of photos (of NHS staff and patients working together, of gleaming new hospitals, scientific looking lab-technicians, post-natal women doing yoga, hi-tech scanners, syringes, fruit and vegetables, caring and responsive (photogenic) paramedics, pharmacists and happy elderly people). In

total there are 41 photos, 28 data tables, 15 graphs, 12 models, 3 graphics and 6 maps. There are multiple short quotes from ‘event participants’ peppered through the document and also copious use of scientific and academic references cited at the end of each section. This may reflect that over time, in IT terms it has become easier to produce more user-friendly and attractive literature to make cases to the public. This may be linked to the expertise of Management Consultant companies being involved in the production and presentation of such documentation. However, in terms of the shifting Discourse around health care, the centrality and increased use of the word *evidence* to the case for change compared to Tomlinson in particular is striking. The word ‘evidence’ appears 35 times; a classic example being cited below. The word evidence appears 4 times conjoined with ‘based’ (i.e. ‘evidence-based’). The word ‘stroke’ appears 83 times in the document.

‘This report makes recommendations for change. It is based on a thorough, practitioner-led process, and rooted in *evidence* [emphasis added] – gathered from a wide range of people and organisations from the world of health care and from the NHS’s partners in local government and beyond, from thorough reviews of the literature and data, and from the use of a range of analytical modelling techniques. It also reflects a major exercise to hear what Londoners say they want from their health care system. It sets out a compelling ten-year vision for health care in London.’

Reference 6; *Health care for London, a framework for Action* (NHS London 2007; p4)

The emphasis on practitioner led, evidence based change rooted in comprehensive public consultation represents a nuanced, focused approach to strategic change in health care delivery allied to a strong, effective and committed SHA force. The case is made to highlight

historic problems in stroke care – the solutions to which are *additive* in that increased funding will produce improved outcomes in contrast to the discourse of earlier reports such as Tomlinson, which focus on closures and mergers.

A crucial dimension of Darzi's report is his success in placing London stroke care in an international context – this is intimately linked to the role of evidence. EBHC exists within and promotes a discourse of performative practice. Evidence is produced, evaluated and ranked in order to direct practice in rational ways. Proponents of EBHC create 'regimes of calculability' (Dean, 2010). These regimes may be used in politically significant ways. The Darzi Review: *A Framework for Action* (NHS London, 2007) and the subsequent work of the *Health care for London* programme which was instigated to implement Lord Darzi's vision around 6 initial improvement projects (one of which was stroke care) can be interpreted as an explicitly *evidence based* approach to health service reconfiguration. When Darzi's work is juxtaposed with that of Tomlinson and Turnberg it becomes evident that this is a novel development in the long history of attempts to reconfigure London health care. The problematisation of stroke care in London involves the designation of stroke in the capital within an international performative space in which it is made visible as a failing service. The inadequacies which are made apparent by international comparative data herald ethical and economic imperatives to garner support for change.

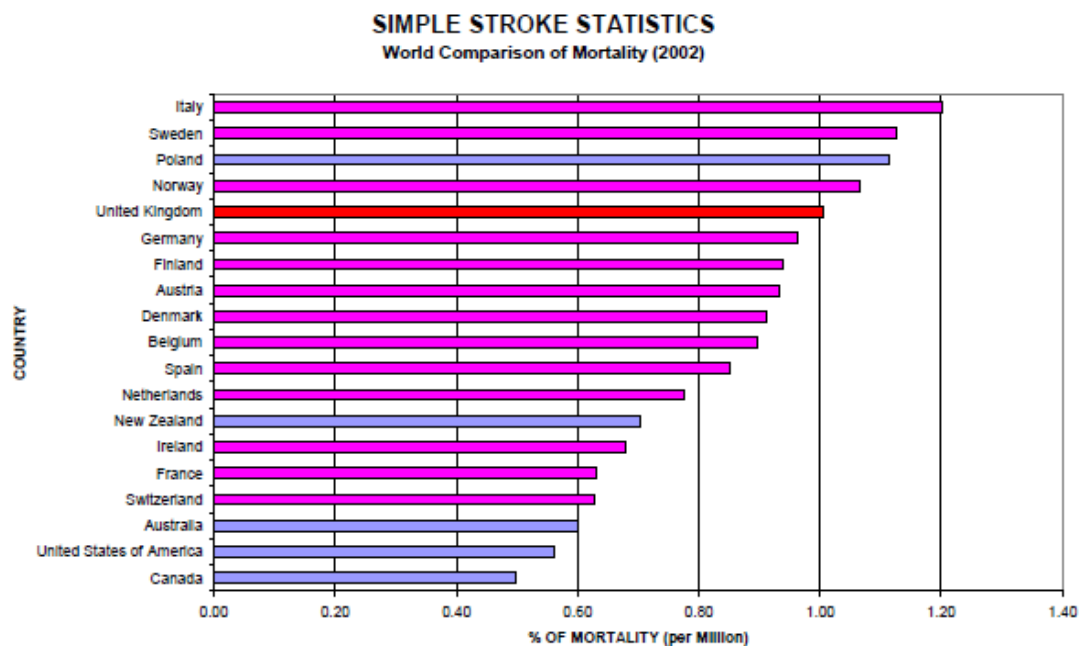
The Darzi Report problematised stroke care in London authoritatively and comprehensively becoming thereby successful in creating a space in which dissent became effectively illogical (Newman, 2001). This is significant because previous (and subsequent) attempts to reconfigure London health services have been hamstrung by popular dissent and a lack of

public legitimacy (Jones, 1993; Clover, 2013). The stroke reforms generated legitimacy for change, and this is the exception rather than the rule historically (Spurgeon et al, 2010).

Below are a selection of graphs, data tables and maps taken from publications produced as part of the Darzi Review and the voluminous Health care for London Stroke Project documentation. These are presented in order to demonstrate the construction of new fields of visibility (Dean, 2010) of stroke in the Capital.

Figure 4: ‘Simple Stroke Statistics’ Appendix 4; *Preliminary Stroke Strategy*. Appendix

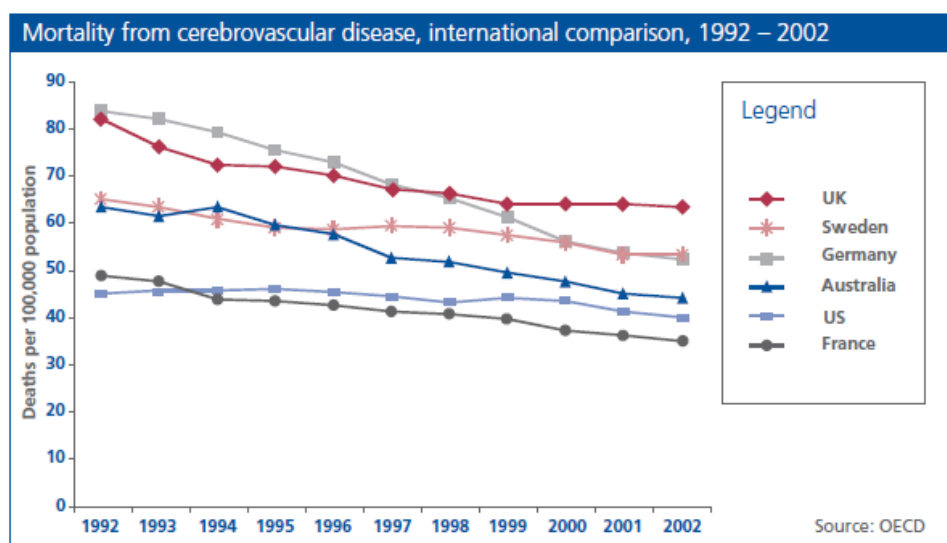
Title: Scale of the problem. (NHS London, 2008e)



This graph (Figure 4) places UK stroke performance in an international context. It highlights the poor performance of UK stroke services in 2002. It visually highlights that amongst this set of OECD countries, the UK is objectively worse than the majority of its international comparator countries. The next chart (Figure 5) highlights that mortality from

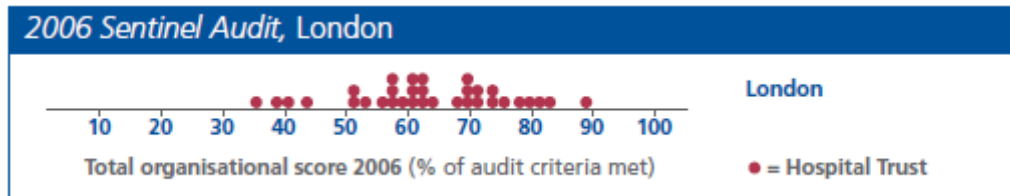
Cerebrovascular disease (CVD) in the UK from 1999-2002 was plateauing at a higher rate than the selected comparator nations.

Figure 5: ‘Mortality from CVD, international Comparisons 1992-2002’ *Preliminary Acute Stroke Strategy for London* (p12) (NHS London, 2008e)



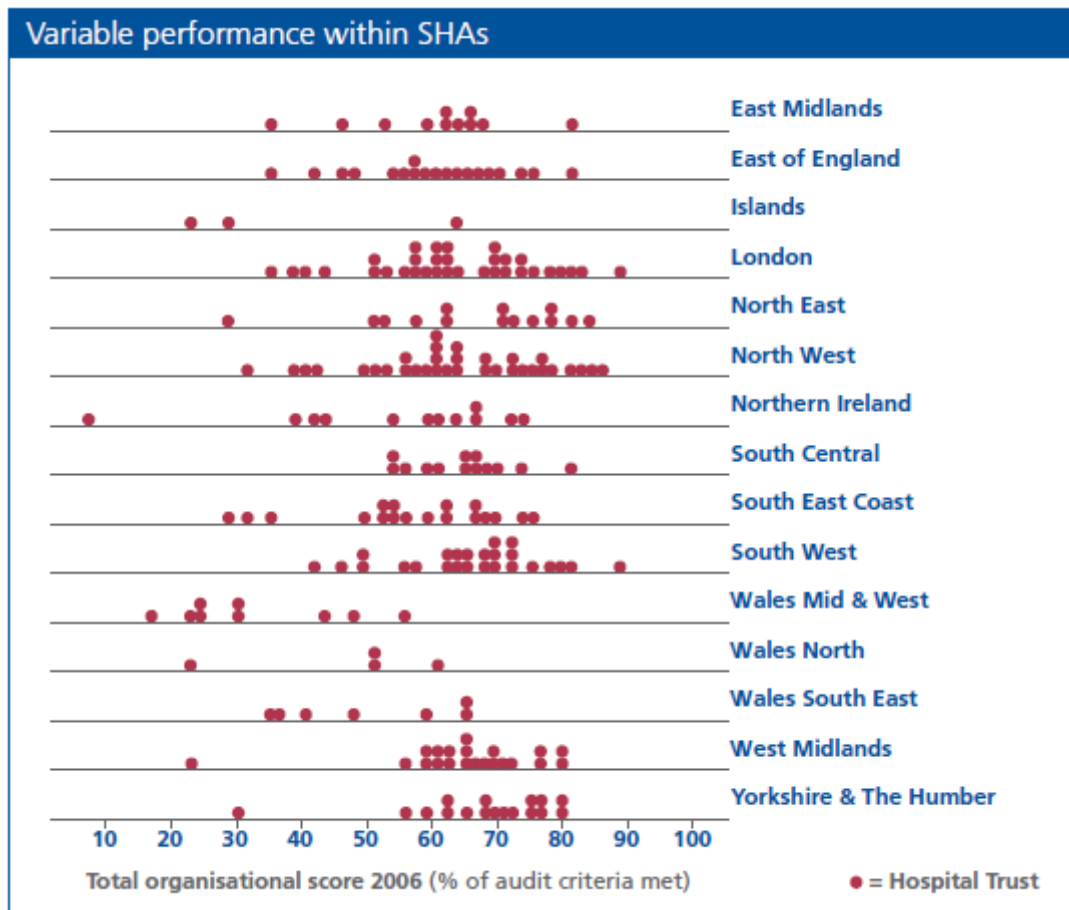
These charts suggest that UK performance in stroke care in international terms is substandard and not improving. The next chart (Figure 6) highlights the extent of variability in stroke performance (as judged against organisational audit criteria) across London’s hospitals.

Figure 6: ‘2006 Sentinel Audit, London’ *Preliminary Acute Stroke Strategy for London* (p4)
(NHS London, 2008e)



These sites are never referred to individually or identified. Figure 7 below then places London Strategic Health Authority (SHA) performances within the context of national performance. A context in which stroke care in London is variable and often suboptimal is created by these charts. Here is clear, irrefutable evidence which highlights clinical and organisational variation presented in accessible, understandable ways.

Figure 7: ‘Variable Performance Within SHAs’ *Preliminary Acute Stroke Strategy for London* (p14) (NHS London, 2008e)



This method of presenting a case for change in health care in London heralded by Darzi and the Health care for London project was new. International and national evidence was used to make stroke failings and variability visible to stakeholders and lay groups. It highlights the power of comparative clinical data and the presentational techniques used are sophisticated in terms of making complex arguments more accessible than previously had been the case in reviews of London's health service configuration.

The Darzi Review of London health services of 2007 and the subsequent work of Health care for London was both qualitatively and quantitatively distinct from the two most recent preceding reviews into London health care (Tomlinson and Turnberg) firstly, in terms of how the Discourse of scientific evidence and employment (and presentation) of international, national and local data was used to depoliticise decision making; and secondly, in terms of assimilating the views and assent of clinical leaders in the capital in the case for change. This reflected the growing importance of the Discourse of EBHC and its potential to establish a shared episteme for professional and management communities to further strategic health care policy making. This may be linked to the development of a ‘biopolitical’ (Foucault, 2007) approach to stroke care in London.

Biopolitics is a term for a form of politics ‘concerned with the administration of the conditions of the life of the population... The concept of the population as a living entity composed of vital processes is essential to biopolitics. Biopolitical interventions are made into the health, habitation, urban environment, working conditions and education of various populations’ (Dean, 2010, p266). The reconfiguration of stroke services in London successfully problematised stroke care in the city as a ‘*London* problem’ for the first time.

Figure 8: ‘Stroke Incidence in London’ *Preliminary Acute Stroke Strategy for London* (p28)

(NHS London, 2008e)

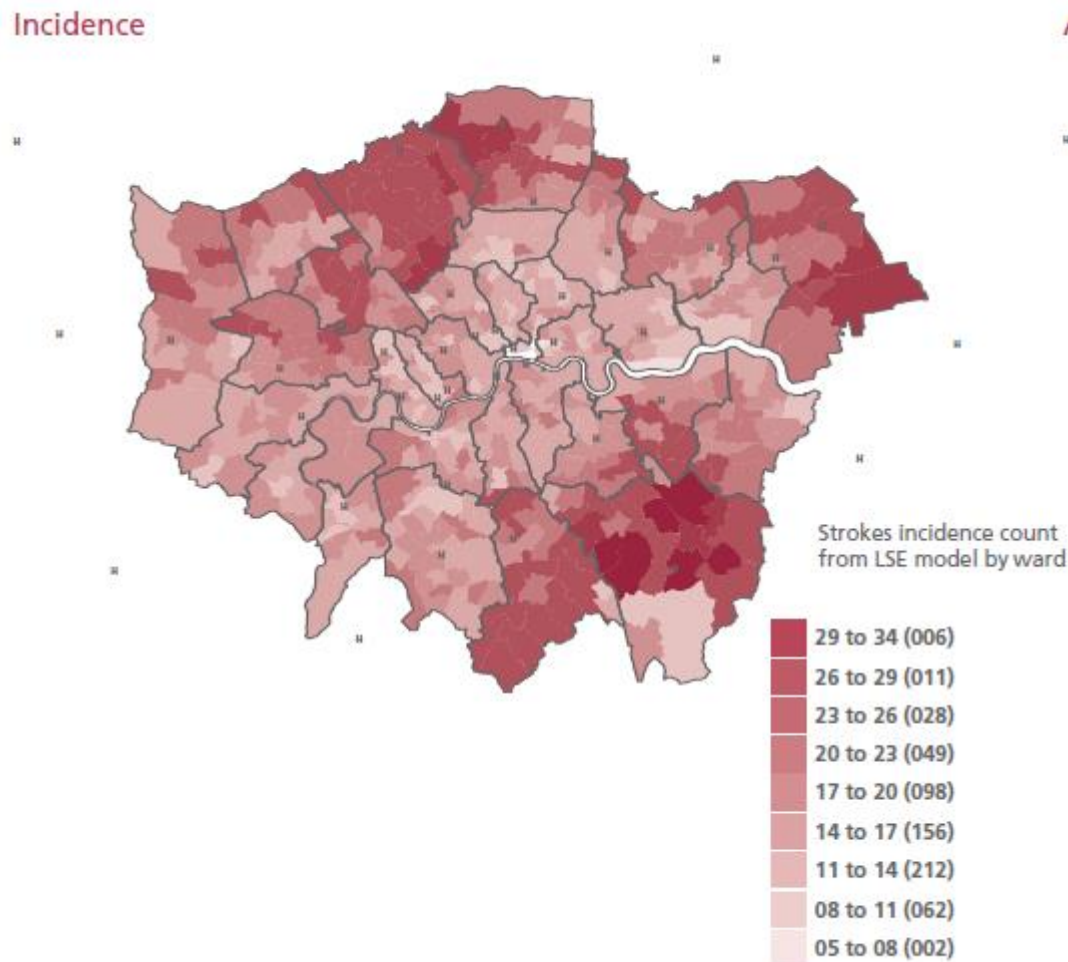


Figure 8 above forms part of a series of maps produced as part of the London Stroke Strategy work by the London School of Economics and published in the strategy documents. Other maps chart ageing, ethnic minority groups and deprivation by concentration and highlight how extensively (or not) the areas in which these different populations are located are served by London hospitals. These represent tangible ways in which stroke as a problem which affects people within the population was made visible and placed in to specific contexts linked to ageing, ethnicity and social deprivation. The impact of this was to present stroke as

a disease which affects certain, defined populations. This in turn highlighted the responsibility of strategic health care leaders and stroke specialists to respond to these population challenges. This validated intervention and radical action.

Stroke, as a modern, treatable disease is relatively recent concept - because it was historically difficult to treat stroke remained a hidden affliction (RCP, 2007). Population maps such as the one above building on the increased data collection introduced by audit techniques such as the Royal College of Physicians (RCP) Sentinel Stroke Audit make inequalities visible and therefore politically open to challenge. Darzi emphasised that this inequality of provision had to be challenged in the foreword to his report:

‘London is one of the greatest cities in the world... The inhabitants of a world-class city should not have to settle for anything less than world-class health care...However, we know at present that whilst there is excellence in health care in London, that excellence is not uniform. There are stark inequalities in health outcomes and the quality and safety of patient care is not as good as it could, and should, be.’

Reference 7; Health care for London, a framework for Action (p2)

The conception of stroke in London in bio-political terms highlights the political, professional and managerial problem of variation in outcomes across the city’s hospitals. A biopolitical view of London as a city sets a frame for the clinical response. A concern for biopolitics and disdain for variation sits closely with an EBHC ethos (Timmermans and Berg, 2003).

‘[In London prior to the reconfiguration] we had extremely good quality services, and extremely poor quality services all existing side by side. So those inequalities were there, the national stroke strategy pointed a way of changing things. The Darzi Report actually also for London, also used stroke as an example of an area that needed reform... And I think they chose [stroke and trauma], because the evidence was strong, that the way you treated patients made a difference. Secondly, because they had the evidence that there were big variations in the quality of care. And thirdly they thought that actually it was a potential quick win that they could put in place.’

Reference 8; Doctor 1, Clinical Expert Panel

An evidence based approach to health care emphasises an ethical dimension which makes acceptance of service inequality difficult for strategic level managers and professionals who take a macro-view of health care. Fundamental to the problematisation of stroke in biopolitical terms at this specific point in history (2006-8) was the fact that for perhaps the first time there was a powerful, unified and financially well-resourced Strategic Health Authority in London committed to a limited number of targeted health improvement goals – of which one was stroke:

‘[I]t wasn’t so much once in a lifetime opportunity, this was about saying, ‘We have this new strategic health authority for London who has a responsibility for looking after the strategic health as it were, of Londoners. And we are going to do these things because it will make a difference.’ So there was a, that was definitely a very powerful

move and there was quite a lot of identification with doing things once for London because all of us who had worked in London had struggled with, ‘How do you get the NHS to collaborate effectively across London?’ And we had failed. So that statement that we are going to do this, albeit top down, which of course some people don’t like, is a very powerful thing, because lot of people had struggled to make change happen without doing that’

Reference 9; SHA Manager 2

The SHA leadership framed the problems associated with stroke care in Pan-London terms in collaboration with senior clinicians and public health academics. There is however, a clear indication in reference 9 just above that the level of collaboration within the NHS in the city which was required to ‘make a difference’ would require a degree of coercion liable to prompt resistance from institutional and professional interests. It suggests that increased control would be necessary to deliver change across such a large population. Closely allied to this was the development of a shared episteme which problematised stroke care in London in biopolitical and evidence based terms. The way that stroke services were characterised in the capital as failing in collective, organisational terms sought to validate a pan-London SHA response which promoted increased control of services as a solution to service variation and poor international comparison status. However, this was about more than just systems, or organisational failings – there were also failures of micro-level regimes of government (Dean, 2010) linked to issues of professional motivation. These also required reformation.

So far it has been suggested that the problematisation of stroke services in London was built upon two propositions. Firstly, that stroke as a disease *can* be effectively managed. The international data presented by Health care for London as part of the ‘case for change’ amply demonstrated that international comparative data highlights that other countries treat stroke more effectively than the UK whilst the National Audit Office Report of 2005 (NAO, 2005) highlighted that this cannot be explained just by economic factors. Secondly, prior to the reforms, within London, some providers produced high quality care (i.e. 90% compliance to evidence based criteria in the RCP NSSA) whilst others did not (40% compliance in the Audit) (see figure 6 above). In biopolitical terms, stroke care for Londoners was shown to be particularly unequal. The problematisation of stroke services in London produced a new approach to thinking about how to govern stroke care professionals in order to standardise and regulate patient care. Evidence of practice and the collection of data were central to this process. A senior manager in the SHA observed:

‘The evidence of what needed to be done differently [in stroke] was strong and there was a compelling sort of clinical case for change and clinical leadership to go with it... And on top of that, it was obviously – our performance was getting worse, not better’.

Reference 10; SHA Manager 1

Stroke performance had become calculable and disparities in performance were demonstrable and it was possible to construct the case for change, the regimes of calculability to monitor those changes, and achievable metrics of success. The use of evidence based performance data in stroke might be viewed as an attempt to reduce professional ambiguity and thus

interpretive spaces or agency for clinical teams or health care organisations to deviate from specified practice. The problematisation of stroke along evidence based lines in London was an attempt to frame stroke care as a ‘canonical practice’ (Brown and Duguid, 1991) in which a shared episteme was developed to agreed standards – once this was achieved then strict measurement cycles could be employed to assure compliance and theoretically reduce performance variation (Noordegraaf and Abma, 2003).

This was not primarily a commissioning or general management drive but established *in partnership* with stroke professionals. In London, the role of senior stroke specialist consultants, and their embrace of measurement techniques was important. There are a number of key professional leaders who participated as clinical expert panel members. They were invited to do so because they had developed or were evidently striving to develop high-performing stroke units in the capital themselves prior to the reconfiguration and had been involved in clinical research and (in some cases) the development of the RCP Stroke Audit. Consultant 2 is a good example of this. He speaks below of ‘change management’ and the power of narratives in convincing senior managers at his hospital to back him in leading change:

‘I learnt with the NHS Modernisation Unit, and also some personal reflections, how to persuade people is, is going to get stories, you can’t get numbers. And you’ve also got to do the basics of change management. So you’ve got to put in some groundwork, which is essentially communicating the idea that there’s a problem in the first place. People were complacent and didn’t feel there was a problem. So we did the Sentinel audit, we came in the bottom quartile. That concerned people. But still numbers...

And then we told a particularly powerful individual story of an experience that in younger stroke patient has, survivor had had – and that one story was enough in terms of, instead of the numbers to get us going in the service.’

Reference 11; Doctor 2, Clinical Expert Panel

This consultant displays political awareness and an understanding of successful techniques to manage change – by utilising narratives as well as hard statistical data to push an agenda of stroke service improvement at a local level. Both means and ends behind the framing of stroke as a ‘problem’ were shared by managers and clinicians. Doctor 3, who is also a successful stroke leader in the capital, suggests below that there were ‘unstated drivers for change’ (Fulop et al, 2005) from his point of view as well as the stated drivers – or the narrative given to managers:

‘Well I think there are two ways of looking at that - there is the way that is always projected to the purchasers and the NHS managers at large, which is that stroke services in London failed to meet optimum standards as set by the Royal College of Physicians... I think there was possibly another agenda which is that the stroke services that were good were in the wrong place... I don’t know whether it was a genuine attempt by people to optimise services because they’re altruistic. But I mean... I was in the position of having a reasonably well functioning stroke service in the London suburbs. There were actually very few of those.’

Reference 12; Doctor 3, *Kenworthy* hospital and Clinical Advisory Group

The clinical leaders in London who collaboratively shaped the reconfiguration appreciated the power of the data produced by the RCP and were aware of the authority that this added to their position and how it could be used to highlight the need for change. They also were aware of potentially ‘hidden agendas’ and how strategically this may impact upon their own institutions. This issue will be discussed in greater detail in the next chapter when the decision making issues around the site selections of hospitals to be provided with Hyper Acute Stroke Units is examined. The key point to conclude this section is that both clinical and managerial communities were aware of the political utility of problematising stroke in the way they chose to by drawing on scientific and performance data to highlight that stroke outcomes were both calculable and susceptible to improvement. Both communities were aware of the importance of narratives, stories and specific discourses in reducing the ambiguities of goals of reform in certain contexts, and hiding ambiguities in other contexts driven by the development of a shared episteme.

5.3 Section 2: The push for standardisation

The reconfiguration programme – including the establishment of the various panels, the production of accompanying literature such as that of Health care for London and the Darzi Report, and the public consultation exercises represent elements of the technical drive to problematise stroke in London within a newly defined episteme committed to standardising stroke care processes and outcomes. A key technical element of the problematisation of stroke was to highlight and question variation in performance across the city, and to make the eradication of this a focus of the reform programme:

‘[T]he biggest single thing we could do to deliver quality in the health service is to take out all the variation. And actually, you know the stroke project in London took out the variation and there’s nothing special about stroke. It was just a systematic way of taking out a variation’

Reference 13; Doctor/Manager 1, Stroke Leadership team

Audit is useful as a technical tool for improving health care (Grimshaw et al, 2001; Boaz et al, 2011). Without the RCP stroke audit, it would not be possible to compare English performance internationally nor London hospital performance regionally. Nevertheless, audit data alone in London had proven to be insufficient to overcome professional, institutional and managerial inertia in response to poor performance.

‘[I]t was amazing to me that people who were performing really badly consistently in the Sentinel audit... [produced] no kind of institutional response to a poor score... it seemed to be that they weren’t asked to present at their clinical governance group, there was no internal response to the fact that they had a really poor stroke service... But really again they... seemed to be hitting a bit of a brick wall at getting services improved... the poor ones had really made no improvement year on year on year, you know, for six years of the Sentinel audits, they hadn’t moved upon them. In fact some of them had got worse.’

Reference 14; Stroke Nurse Specialist, Clinical Expert Panel

This quote demonstrates the limited utility of stroke audit data in its pre-reconfiguration form. Audit as a measurement tool was professionally owned – hospitals were obliged to facilitate a response which was sent to the Royal College of Physicians and analysed and subsequently published. As will be demonstrated in subsequent chapters – stroke audit in London is transformed by the reconfiguration to become a much more effective tool in both clinical and managerial terms. This respondent suggests the audit ‘failed:’

‘[T]he audit had failed... that audit never really fed back an effective change in a systematic way across a town, for example. So a big bang was probably an alternative approach. And, of course, there were financial incentives [in the new London model].’

Reference 15; Doctor 4, Clinical Expert Panel

The RCP Sentinel Stroke Audit was essentially passive as a programme designed to reform services because for a number of years organisations were able to ignore poor reports. It was a system of measurement that was insufficiently meaningful to key decision makers within hospital trusts, PCTs and SHAs. The historically weak position of stroke as a specialism and its proponents’ perceived lack of influence in jurisdictional terms (Abbott, 1988) compounded the inability of the audit to challenge performance variation effectively:

‘Stroke historically has been a geriatric speciality, but it’s not been a glamorous speciality. And historically there’s been very little in terms of investment into it as a speciality. Now clinicians were always arguing that more attention has been brought to bear on stroke. But, to be honest, I think a lot of clinicians were a little bit disenfranchised with the entire process. They saw other things, other specialities getting a lot of attention, and quite rightly, but not a lot towards stroke. And it took a bit of political manoeuvring for it to, for people to suddenly realise that how, what could be done for stroke and what wasn’t being done for stroke, what – almost, not half-hearted, but what suboptimal advances had been made, for instance, stroke units being put up but not everyone getting to the stroke unit.’

Reference 16: Doctor 5, *Kenworthy* Hospital

A key factor therefore in changing this situation, and increasing the influence of stroke care data was to create a ‘big bang’ and link audited stroke care performance with prospective financial inducements for institutions:

‘[R]emember that we’ve got 31 PCTs in London to commit an additional £20 million for stroke care. So on the basis that we were putting all that money in, we’d better demonstrate that we’re doing something with it. And you don’t get the money unless you demonstrate that you’re meeting these qualities.’

Reference 17; SHA Manager 1

Extra money is linked to standardised performance for institutions as a way to engender support from senior hospital management. This highlights the role of targeted, interventional commissioning to promote clinical improvement and an explicit link between hospital finances and clinical performance against evidence based benchmarks measured by more prescriptive data collection. This also suggests that economic and ethical drivers for change can be mutually inclusive and appeal to both professional and managerial stakeholders. So, variation of performance was highlighted as a key target of the London Reconfiguration of Stroke Services. This was shown to be the case through clinical audit data, but clinical audit of stroke itself was seen to be insufficient in eliminating variation across providers. Therefore a crucial element of the proposed new regime of government (Dean, 2010) was to link audit data with increased funds from commissioners to incentivise hospital management to prioritise stroke in new ways within their institutions. Audit becomes monetised and a significant concern for managers as well as clinicians. Clinical performance therefore becomes subjected to greater managerial surveillance. Paradoxically, hospital managers too now would become more dependent on clinical performance to validate their own positions as part of this new regime of government. This impacts upon the subjectivities of those involved – as discussed below.

It has been suggested here that the presentation of stroke care as a variable, and essentially failing service in London was a political strategy pursued by policy makers, managers and elite professionals with a number of implications. The idea that some services are demonstrably better than others in the city (see figure 6 once more) placed failure and success in the realm of human behaviour (Stone, 1989) and organisational systems and therefore

amenable to improvement through systems augmentation and individual agency. Leaders (principally professional rather than managerial) were selected from successful hospitals to be involved in designing the new regimes of government. This implicitly created a distinction between ‘better’ and ‘worse’ professionals and institutions – this impacted upon the subjectivities of these leaders and on rank and file staff. It also tied stroke care into a performative London-wide discourse in which *all* professionals submitted to greater data interrogation and regimes of measurement. The below quote captures a number of issues related to failure, staff subjectivities and pre-reconfiguration problems effectively, and is representative of many of the views expressed by respondents involved as clinical experts in the reconfiguration process:

‘I think there had been some units where stroke had been never a priority for the individual institution; I think the awareness of stroke as a specialty was quite poor in those institutions. I think there was no internal clinical leadership from a stroke team, pushing these forward. But that wasn’t always the case, and we came across some places where the stroke clinician had basically been fighting for years and years and years. And in fact for me *Kenworthy hospital* was a really good example of that. You had a really good clinical lead who was really passionate about stroke, that could not get Trust engagement for any kind of reorganisation internally, any kind of financial commitment from your staff, but a real desire for him to see things improve. So there was a bit of a range actually. And there were some Trusts and some clinicians who frankly couldn’t have given a monkey[s] about the stroke care and it really wasn’t their priority, they were much more focused on their geriatrics covering neurology work and it was a bit of a Cinderella service.’

Reference 18; Stroke Nurse Specialist, Clinical Expert Panel

The first point here is that in failing institutions (vis a vis stroke care) stroke was not prioritised and the blame for this is laid at the door of the stroke team, and in particular – the leaders of the team (rather than institutional management). This prompts two points – firstly, the importance of leadership in promoting clinical change, and secondly, for clinical leaders such as this informant, that the agency for change and hence the responsibility for promoting this resides with leaders and professionals –individually and collectively. She then suggests however that leadership and commitment *per se* are not always enough, citing the case of *Kenworthy* hospital (which will be explored in much greater detail elsewhere in this thesis) where organisational inertia hindered the leadership drive and application of agency was overcome by structural disinterest. The final sentence is of great interest however – some organisations and clinicians marginalised stroke and therefore provided substandard care because stroke did not fit into their own agendas or perhaps align with their chosen professional identities as geriatricians or neurologists.

This view suggests that professional leadership is an important factor in service improvement; professionals have the agential power to push for change, but may choose not to perhaps linked to their own ‘identity work’ (Sveningsson and Alvesson, 2003) and how stroke as a specialist discipline correlates with their own subjectivities. However, ‘failure’ is more than just a professional agency issue – it is also structural – some institutions have tended to hinder and suppress the agency of stroke clinicians to deliver improvements in care. Traditional stroke care failure was identified as a problem linked to both professional agency and managerial indifference. The following quote highlights the moral imperative to challenge such failure:

‘[I]f my family would have lived around here five years ago, if [a family member] they had a stroke, I would have driven up to *Burridge hospital*. And, you know, if five years ago if they’d had a stroke in *Porterfield*, I would have driven them up to *Deane hospital*. So, but actually, you know, to not do anything about that is completely reprehensible if you know that’s the case. You can’t be the chief executive in a hospital where you wouldn’t want people you knew come in to have, to be looked after. It’s just not; you should resign if you’re happy to accept that sort of terrible situation’.

Reference 19; Doctor/Manager 1, Stroke Leadership team

Stroke leaders (managerial and professional) involved in the design of the reconfiguration programme in London highlight the ‘ethical’ imperative which compels them to challenge inadequate stroke care. Once it is clear that better outcomes are possible for patients – then not to strive for those becomes ethically questionable and impacts upon the subjectivities of those involved in delivering and shaping stroke services. A further organising logic which influenced the development of the new episteme of stroke care in the London reconfiguration programme was economic efficiency and the traditional inefficiencies of the status quo ante:

‘[W]e spent as much as the highest spenders in Europe per individual stroke patient, but were getting significantly worse outcomes. So the issue did not necessarily seem to be a lack of spending on stroke care, but the fact that it wasn’t being delivered well across the board and outcomes were just not improving.’

Reference 20; Network Director 1

In organisational and management terms, stroke traditionally had delivered a poor return. Therefore changing the current arrangements was attractive and drew on language emphasising ethical and economic logics:

‘And it wasn’t too expensive. In fact it might have been cheaper and it made a real difference.’

Reference 21; Network Director 2

The discourse around value for money permeates the responses of many informants whether predominantly clinical, managerial or otherwise (for example patient group representative – see Reference 23 below). There was a palpable sense that the service could deliver so much more in terms of both patient health and economic outcomes – so as well as being ethically wrong not to provide evidence based stroke services, it was also uneconomic. This had been a key element of the National Audit Office (NAO) report findings in 2005:

‘So I didn’t know anything about stroke before I came to manage it, but if you read that report [NAO Report] and you go, ‘This is shocking.’ ‘It is utterly appalling. We have to do something about it and we can.’ And so the, the fact that it was so compelling, that something needed to be done and could be, certainly made a big difference in terms of stroke.’

Reference 22; SHA manager 3

The charity representative below locates the sense of frustration felt by patients within the NHS as an organisation fusing the ethical and economic elements of failure:

‘[O]n learning that actually significant disability might have been reduced or avoided, not by a huge extra expenditure and finance but simply by the NHS getting its flaming act together and organising itself effectively – the comment from many stroke survivors was that they felt cheated. They felt that they were the victims of NHS poor organisation. So that was a powerful... driver for us to try and force through and pressurise change’

Reference 23; Charity Representative 1, Stroke Project

This sense of patients feeling ‘cheated’ provided a powerful narrative to make the case that change was needed and concretised the professional and managerial arguments for change. The location of failure within professional actions and organisational (hospital level management) structures had implications for the ways in which the regime of government which emerged to rectify these historic problems was framed and how power was distributed. This is discussed further below.

5.4: Section 3: Building a consensus and accounting for conflict

It has been suggested in this chapter that the Darzi review of London's health services was more successful than previous reviews such as Turnberg and Tomlinson for a number of reasons; Darzi's review was more thoroughly embedded in the Discourse of EBHC and more inclusive of the practicing London health care community and focused more on additive change as opposed to rationing and closing services – essentially the focus is on 'evidence based' quality improvement rather than economic rationalisation of services. For the first time, in NHS London and the Health Care for London project, there existed a powerful, well-resourced central SHA with the remit and desire to push through change. However, in spite of all this, NHS London leaders faced cynicism and scepticism from many in the hospital stroke community at the outset:

'[A senior clinical manager] and I got all the stroke physicians in London together in a room. So you would have expected that group to be like fantastically enthusiastic and supportive, wouldn't you? You know, out of all the things that they could have picked, they picked our speciality, they've poured all this money into it, they're going to make it – and they just sat there, they were all like that – saying, "No it's not going to happen, it's not going to work, it can't be done, nobody will follow it through.'

Reference 24, SHA Manager 1

There are a number of reasons why clinicians might be expected to be less enamoured with change than the manager in Reference 24 above had hoped they would be – though she was

clearly disappointed by the level of cynicism. The Darzi report painted a vision for the future health care landscape in the capital which included increased concentration of specialist services in fewer centres and a push to reduce beds in District General Hospital style providers and increase the role of ‘polyclinics’ and care delivered close to patients’ homes (Darzi, 2007). Though the plans for stroke and trauma were more successfully implemented than those for primary and community care (Appleby et al, 2011) at the outset, fear and cynicism were not unreasonable first reactions from professionals faced with upheaval:

‘[I]f you look carefully at what Ara Darzi had described for London, he essentially described London as being run by three kind of, three to four teaching hospitals in the centre of London... And I think people saw that having a hyper-acute stroke unit gave you your place as the major acute hospital round the outside.’

Reference 25; Doctor/Manager 1, Stroke Leadership team

Although Darzi set out a ‘vision’ for London, his report was not explicit about exactly which hospitals will provide which services, and although much was made of concentration of specialist services, much less was made of the corollary - the down-grading of non-specialist providers. Some hospitals grasped the implications of this more completely than others - as a management consultant involved in putting a bid together for *Kenworthy* hospital observed:

‘[T]he hospital felt vulnerable, it could see that change was coming and it was beginning to realise in a way that it hadn’t previously, that the DGH was dead. But actually if it had a future, if it had a future [then it was] as a major acute hospital.’

Reference 26; Independent Management Consultant, *Kenworthy Hospital*

Significant here, is how stroke increases in importance as a disease type for board level managers within London's hospitals. However, the vulnerability felt by certain institutions (as outlined in reference 26) and the cynicism of many stroke physicians (cited in reference 24) still needed to be overcome to legitimise the concrete responses to weaknesses identified and plans suggested to overcome these by the Darzi report. The SHA drew on the skills of Management Consultants to lead the Health care for London stroke project and bring stakeholders together to discuss the implications of change and prospective models of delivery:

'[T]here were some very big stakeholder events which were organised by Health care for London and they invited all the clinicians involved, the public, stroke survivors, the voluntary sector, all the networks were involved. So I think there were at least three and possibly four large stakeholder meetings where progress of the project was discussed. There were then sort of workshops in the afternoon where particular questions were asked of tables and people were invited to, to contribute. And certainly I know that a number of the clinicians who disagreed with the model attended those stakeholder workshops... [They] were given the opportunity to have their views presented and heard. But they are in the minority. If they were in the majority I don't think the model that we've got would have been chosen.'

Reference 27; Network Director 1

The technique of holding stakeholder meetings was useful in engaging with staff and the public and generating legitimacy for the proposed solutions. As this respondent suggests, critical professionals aired their concerns, but were in the minority. Perhaps equally significant was that the Health care for London team managed the process very skilfully:

‘And I think that’s one of the points of why it worked in London because what we then did; we had our first pan London conference. And that was attended by representatives across London... And we mixed everyone up and we eventually workshop[ped ideas]... But we kind of had the answers in our back pocket... And we were able to ... [guide] that conference to an answer that we had already, I suppose, decided on. But you were getting 150 to 200 people almost agreeing on 99.9% of what the problem was and how to solve it... And there was a lot of issues around the 5% and 10%. [but] everyone agrees on the 90 odd percent.’

Reference 28; Management Consultant Lead for Stroke Project

This sense of strategic coherence to the project was very strong. Numerous informants cited the role played by the Management Consultancy leadership in keeping the focus firmly on the goals of the project and creating consensus amongst professionals representing institutions that had often been hostile to each other. Informants warmly cited the project management skills of the management consultants, but also their ‘independent’ status – without institutional ‘axes to grind’. Another ‘independent’ voice involved was that of the stroke patient charities:

‘We weren’t going to say *Morris hospital* should go, the *Dempsey hospital* should stay, *Edwards hospital* should stay, *Arnott hospital* – we wouldn’t play with that. But what we would do was play with, was robustly say it is absolutely correct that there should be a smaller number of HASUs in the centre and a larger number of HASUs in the outskirts. That we could come out with.’

Reference 29; Stroke Charity Representative 2

Such an ‘independent’ voice, focused on the patient experience allied to the project management knowledge of the management consultants employed by NHS London was key to transcending the traditional institutional debates and building consensus amongst those consulted on how to turn Darzi’s vision into reality. Nevertheless the remaining part of this chapter presents data that highlights firstly; the interprofessional and epistemic implications of constructing stroke as an ‘emergency’ condition in London and how this shapes the London model of care and competing forms of evidence. Then secondly, the contingent nature of the London model itself with the aim of challenging the ‘taken for granted’ elements of regimes of government and practice (Dean, 2010).

The metrics used to problematise stroke as an acute, emergency condition impacted upon the kinds of evidence considered more or less valid for the designation of the London model of stroke care in the capital. It is suggested here, that the Randomised Controlled Trial type ‘gold standard’ evidence prioritised in medically dominated Evidence Based Medicine Discourse had more legitimacy amongst the key leaders (professional and managerial) driving the reconfiguration than evidence produced by the AHP or nursing communities. This

led to a marginalisation of rehabilitation and community based care evidence in particular and a focus on acute care reform. This in turn suggests that different types of evidence created and championed by separate epistemic communities impacted in variable ways in the framing of stroke care as problem in London. This in turn influenced the shape of the London model further down the line.

The first point to make is that there was a consensus amongst many respondents that there was not only just more evidence (by volume) around acute care interventions and strategies in stroke than for either preventative or rehabilitative interventions, but also that this evidence was of a higher quality:

‘[T]he evidence base was predominantly around thrombolysis and acute interventions in the period immediately post the stroke. And the evidence base for rehab was absolutely crap.’

Reference 30; SHA Manager 2

‘Well actually that’s [acute care] where the evidence was strongest, that if you make the change, you’ll see the quickest results, benefits. [Therefore] it was perhaps the easiest thing to do.’

Reference 31; Doctor 1, Clinical Expert Panel

The sense that there was more evidence for acute interventions and that it was of a more convincing nature than that for post-acute care created an environment in which it became pragmatic to focus on acute interventions. Nevertheless, there were contrary views expressed by participants in the reconfiguration to say that there existed good evidence behind rehabilitation interventions. This was expressed in documentary evidence submitted by the Allied Health Professions Federation (AHPF) as part of the wider consultation process on the shape of the London model in May 2009. The AHPF coordinated the response of The College of Speech and Language Therapists, The College of Occupational Health Therapists and the College of Paramedics and stated that the London reforms must consider the whole pathway for stroke care more effectively and ensure that AHP staffing issues were sufficiently prioritised – both in the hospital setting and in the community (AHPF, 2009). Informants also suggested that therapies evidence and influence was marginalised:

‘You know, it was wildly criticised... [the focus on acute care] I’d say, from the stroke community, you know, particularly people in the rehab end, because obviously there’s a lot of evidence based [research] around rehab. So it wasn’t a very popular decision.’

Reference 32; Network Director 3

These data overall suggest it is quite rare to find dissent from those involved around how stroke was problematised which makes the above quote of significant interest. It reflects a view articulated by members of the rehabilitation community that their knowledge base and expertise were marginalised in the process of identifying problems with stroke in London and prioritising solutions. The respondent below was particularly eloquent on this subject. A

physician, his background was as a Care of the Elderly Doctor, who had spent many years building up integrated hospital and community services for stroke patients in his sector of the city:

‘From a rehab background, I can see that it’s politically correct to focus on holistic care and all that. And I’m totally signed up to it. But I’ve been convinced by all of the evidence, both randomised trial and observational and the recent stuff that, you know, if you get acute care right, you have a different condition, in fact, with lots of people going home early and it’s much cheaper.’

Reference 33; Doctor 4, Clinical Expert Panel

He argues both in evidence based terms, and building on his tacit or experiential knowledge, that it made sense to concentrate resources and focus on the acute phase of stroke care as it would lead to the most effective quality of care improvements and economic savings. This argument may become self-perpetuating. For example; acute care has the strongest evidence of efficacy, therefore it should be prioritised. Next, in order to justify this prioritisation, a tighter audit regime is required in order to measure performance in formal terms. Thus it becomes harder for proponents of care that is perhaps more difficult to measure (prevention, rehabilitation, community therapies) to challenge this performative agenda.

This leads to questions around the scope of the reconfiguration as a whole. Amongst respondents there was dispute around this point – but overall a consensus that although the focus originally was to reconfigure the entire stroke pathway – from emergency to

community care (and prevention), the reconfiguration instead morphed to focus on acute care:

‘[T]here’s the HASU, the first 72 hours and then there’s the kind of long term care, rehabilitation, survivorship, all that stuff. And we wanted in the strategy, when we published the strategy; we wanted to give equal weight to all three of those bits. But, but frankly the institutions got so excited about the 72 hours that we spent, you know, certainly 50% of our time dealing with that 72 hours and not as much time setting high standards about prevention, primary and secondary prevention and rehab got, not kind of forgotten, but, but downgraded in terms of its importance.’

Reference 34; Doctor/Manager 1, Stroke Leadership team

Although there was a rhetorical commitment to ‘whole pathway change’ based on evidence based criteria in the official documentation of the reconfiguration, in reality this does not appear to have happened. Indeed, the publication of the *Stroke Rehabilitation Guide* in November 2009 recognises the acute focus of the work done by NHS London and the need to develop rehabilitation services further (NHS London, 2009a; p7). Reference 34 above suggests that the institutions ‘got so excited’ about the acute phase of care that the project team spent half their time on this area of stroke care. This highlights the messiness of the process in many ways and the disparities in institutional power of different players involved – especially the dominance of certain powerful hospitals. These issues will be discussed in the next chapter at more length in relation to the ways in which the site selection of the HASUs gained significance. However, it is worth being explicit here. The London model required

increased funding targeted at stroke (£23m P/A); it also required increased specialisation at a reduced number of London hospitals. This created a spectre of competition between London hospitals as well as community services. Guided by the performative values of EBHC and tariffs linked to outcomes, it was the acute providers which had the most to gain or lose from the reconfiguration. These institutions also employed the individuals with the most structural and normative legitimacy (Lockett et al, 2012) in the city (stroke specialist consultants) – many of whom were intimately involved in the production of academic knowledge related to stroke care and key roles on clinical advisory panels.

Medical evidence around acute care interventions was seen as the strongest evidence base to drawn upon and therefore dominated the establishment of the new stroke care episteme for London. This ensured that most of the extra funds provided by the PCTs went to acute care providers (hospitals). This form of ‘medical dominance’ manifested itself in not only epistemic terms but also the group dynamics of decision making. A therapist involved as a clinical expert panel member described her experience on the panel in the following terms:

‘I would describe it as one of my most uncomfortable professional experience[s]; because I kind of felt that I was there to tick a box, ‘Oh we’ve got an AHP representative on there.’ ... I felt completely the minion. And it wasn’t, it’s nothing about the personalities, it was just the fact that it was so medically dominated, I felt quite pleased with myself for managing to get a couple of sentences in per meeting and there is no way on this earth, I didn’t have, I didn’t have counter evidence to offer them. There is no way I would put my head above the parapet and challenge what they were saying.’

Reference 35; AHP 1, Clinical Expert Panel

The marginalisation of therapy voices during the process of discussing clinical prioritisation was noted by other (theoretically impartial) respondents – particularly managers:

‘[E]veryone thought rehabilitation was important, but it was all terribly difficult and we didn’t have a consensus of rehabilitation leadership as to what the right answer was. So it would – maybe the regret is that we didn’t work harder to find those powerful clinical voices that said, ‘Yes it’s very difficult because there is no consensus about what the, what the rehab delivery model ought to be, but I’m going to nail my colours to the mast and we should do it this was across London.’ And maybe we should have looked harder for those clinical leaders. But believe you me, they didn’t emerge naturally’

Reference 36; SHA Manager 1

These respondents suggest that personal dynamics and ‘leadership’ in terms of sense-making (Pye, 2005; Weick, 2005) are important in expressing a case for a particular epistemic view point and that they were lacking amongst the AHP community. A subtle distinction about medical leadership is made below:

‘Well I think it’s fair to say there was a very strong focus and leadership, which does mean that you have to say, ‘We’re doing this, we’re not doing that.’ ... I think it’s

wrong to think that it [the reconfiguration process] was dominated by doctors, but it was dominated by rehabilitation doctors who decided to do something outside of rehab as well [i.e. focus on acute interventions].’

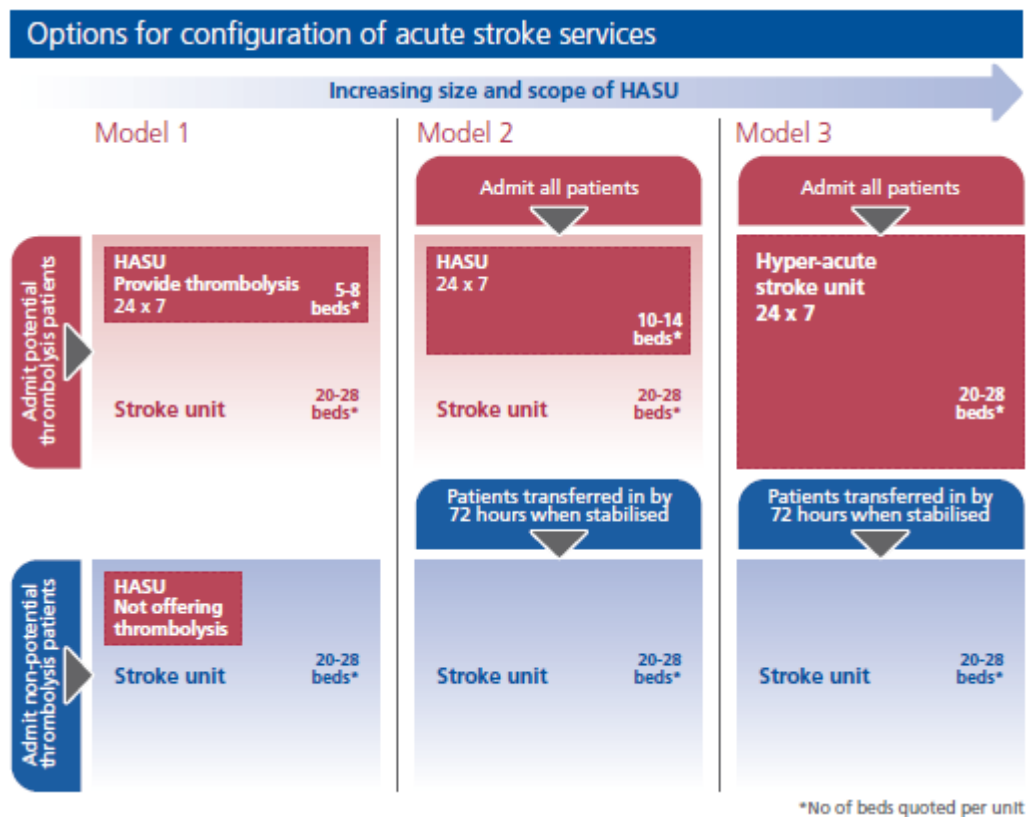
Reference 37; Doctor 4, Clinical Expert Panel

Overall then it appears that medical evidence was prioritised over other forms (i.e. therapies’ evidence) in the way in which stroke care was problematised in London. Despite an initial commitment to reform the whole stroke pathway, in reality the chief focus was on the acute (medically dominated) part of stroke care. This is linked not just to differential epistemic persuasion and calculability issues, but characteristics around ‘knowing’ (Ceci, 2004) and issues of leadership, as well as the structural interests of powerful (acute care) institutions. The dominance of medical evidence shapes the coherent episteme in which these reformed regimes of government are developed in general terms prioritising acute care redevelopment. However in terms of specific models to deliver the new episteme there were a number of options which were devised - these are now explored.

The remainder of this chapter compares official documentation relating to the proposed solutions to the problems of stroke care in London with the perceptions of key informants involved in the construction and evaluation of the competing models. This analysis will distil some of the key technical principles behind the resultant model and demonstrate how clinical evidence and managerial priorities may interplay with one another. This section will firstly describe the three different models of delivery developed by Health care for London and the methods used to evaluate these models with recourse to NHS London documentation.

An important point with respect to the London reconfiguration was that nothing on the same scale had been attempted before – no other city of this size had attempted to rationalise and specialise stroke services in this way (though there are smaller scale comparable examples such as the work done in Ontario cited in the Health care for London literature). This clearly has implications for an evidence based approach to decision making in that there is little to draw on in terms of ready-made, tried and tested models to import or copy. Therefore the clinical expert panel came up with three different potential models which are presented in the Preliminary Acute Stroke Strategy drawn up by Health care for London (see figure 9).

Figure 9: ‘Options for configuration of acute stroke services’ Taken from *Preliminary Acute Stroke Strategy* (NHS London, 2008e)



These different models offer different advantages and disadvantages and are described in the official documentation thus:

‘Model 1: A large number of small-sized (five to eight beds) HASUs situated within SUs, some of which will cater for thrombolysis and others which will not. Model 2: A large number of medium-sized (10-14 beds) HASUs situated within SUs, catering for all patients within the first 72-hour stabilisation period, and then transferring patients to adjacent SU beds or repatriating patients to a SU nearer to home. Model 3: A small number of large-sized (20-28 beds) HASUs, catering for all patients within the first

72-hour stabilisation period, and then transferring patients to adjacent SU ward or repatriating patients to a SU nearer to home’

Reference 38; *Preliminary Acute Stroke Strategy* (p6) (NHS London, 2008e)

The key issues are that model 1 was the closest to the *status quo ante* and therefore required the least change, but also the smallest extension of specialisation – it also (by having different admissions procedures for potential thrombolysis patients compared to non-thrombolysis patients) potentially perpetuated variability and placed a significant diagnostic burden on the London Ambulance Service (LAS); in contrast, models 2 and 3 offer greater standardisation by admitting all stroke patients to HASUs (regardless of whether they were candidates for thrombolysis or not). At an early stakeholder event the project team invited participants to evaluate the various potential models using criteria developed by the clinical and social care panel and commissioning and finance panels respectively. This led to the following set of criteria and weighting of factors by importance: ‘Quality of service 39%, Continuous improvement 14%, Critical mass 9%, Travel times 9%, Health inequalities 8%, Implementation 8%, Cost/ efficiency 7%, Network working 6%’ (Appendix 22 Health care for London, Evaluation Criteria Process; NHS London, 2008f; p5). It was agreed that this list would ‘be used to evaluate the best option from the proposed models as well as evaluating the options for the configuration of stroke services across London’ (Appendix 22 Health care for London, Evaluation Criteria Process, NHS London, 2008f; p6). Section 5.6 of the Preliminary Acute Stroke Strategy asserts:

‘A preliminary analysis of each option has been completed and this points to model three as being the ‘gold standard’ option... Quality of service was weighted at 39% by stakeholders, and model three will deliver the highest standard of care in both HASU and SU settings. The fundamental reasons for this are: (model three)

- signals and delivers a step-change in the level of care;
- has a greater ability to recruit and retain highly skilled multi-disciplinary teams due to the size of each unit;
- results in a greater consistency of care experienced by patients.’

Reference 39; *Preliminary Acute Stroke Strategy* (p52) (NHS London, 2008e)

Model three equated to roughly 6-9 HASUs for the city. The use of the term ‘gold standard’ is significant as it has strong connotations with evidence based medicine (e.g. Timmermans and Berg, 2003). The use of such terminology is deliberate; however, those involved in the processes of model design and evaluation acknowledge in the interviews that there is no ‘gold standard’:

‘Now, was there an evidence base that said around seven was the right answer? I don’t believe there was. Was there an evidence base; was there at least a strong an evidence base in clinical evidence terms that 12 to 16 might be the right answer, which was one of the things that was being discussed at the time? Yes, so if you look at the evidence base about hyper acute care, at the time we were doing what we were doing, nobody had hyper acute units of anything like the size that ours needed to be in order

to achieve around seven as the answer. Nobody did... But no evidence underpinned, so far as I am aware, the scale that we decided to operate at.’

Reference 40; Stroke team project manager 2

The interview data consistently affirms that there was a paucity of data as to the best way to roll out HASU care for a densely populated city of 8 million. However, there was a belief that treating increasing numbers of stroke patients at fewer individual units would *probably* be beneficial:

‘They [Programme Executive Group] were very strongly weighed by the fact that you needed a certain number of patients to treat. In fact, the only evidence and the literature about the intensity of activity having an impact on outcome in stroke, it came from a study from Germany, Peter Heuschmann and Co who showed that in hospitals which treated more, thrombolysed more than 50 patients in a year, that the outcomes were better than those where they did less than 50. There’s some evidence from myocardial infarction and some of the other conditions, about the intensity. And certainly some evidence from surgical specialties, but there wasn’t specifically for stroke. And the numbers were rather arbitrary’

Reference 41; Doctor 1, Clinical Expert Panel

This view was confirmed by other members of the clinical expert panel, for example the senior stroke nurse involved in the project opined:

‘So there was one paper that documented about thrombolysis and the fact that the more cases you did over the number of 50 per unit, you were probably safer and had less mortality... But interestingly, since then, there’s an opposite piece of evidence from the implementation of thrombolysis in Europe that shows that actually even new units can do it safely.’

Reference 42; Stroke Nurse Specialist Clinical Expert Panel

Overall there was contestable clinical evidence around HASU numbers and overall designation but a belief that staff experience of treating certain volumes of patients may be advantageous, but little of it stroke specific. In the end, the model involved compromise for key professionals and pragmatism around staffing levels and on-call rotas:

‘So a model was put into place with the eight hyper acute stroke units and another sixteen stroke units in addition to the eight. And so a total of twenty-four stroke units, which many of us, including myself, argued was not right. What we did agree was that we needed a centralised, a hub and spoke model that we couldn’t continue to provide the sort of level of care in every single hospital. And that was a pragmatic thing, it wasn’t based on evidence. It was based on the evidence that actually we needed to get people into stroke units, they need to be seen by specialists and they need to have access to thrombolysis. And that was important to do regardless of whether it was 10 o’clock on a Saturday night or 10 o’clock on a Monday morning.’

Reference 43; Doctor 1, Clinical Expert Panel

Rather than clinical evidence driving the modelling, key informant interview data suggests the challenges of staffing 24 hour thrombolysis (and non-thrombolysis) acute stroke care cover were central to the decision making process around the constitution of the London model. The concerns and decisions are around the most pragmatic ways to manage organisations so as to be able to utilise staff specialist skills as efficiently as possible. This was about rigidity, control and standardisation – in the new system, there could be no distinction between *‘10 o’clock on a Saturday night or 10 o’clock on a Monday morning’*. The relationship between clinical evidence and organisational reforms was mediated by workforce concerns:

‘[I]t was much more about workforce, much more about workforce. So if you were going to have a 24/7 rota of people who could really read the scans and give the drugs and/or just provide immediate care for people who had had stroke, even if they weren’t eligible for thrombolysis. And you wanted that and if you were going to have that where it was best, that people either present on site or they knew the person they were talking to on the phone, then you needed at least eight doctors who were able to do it to give you a 24 hour rota at consultant level. And actually all the better if you had more’

Reference 44; SHA Manager 2

Linked with quality of care is staffing levels and round the clock consultant cover which draws more heavily on organisational data and staffing pragmatism than ‘gold standard’

clinical evidence. A further key development at this stage which became ever more significant was a firm management commitment to stick to an agreed model once chosen, irrespective of complaints from clinical colleagues:

‘[T]here might be two or three other ways in which you can do it. But what you do want is, you do want a relatively purist model once you’ve gone for it. So if you have too much compromise, you end up the worst of both worlds.’

Reference 45; Doctor/Manager 1, Stroke Leadership team

Regardless of the strength or type of the evidence used to justify the chosen model, the senior team leading the project were clear that compromise in delivery was a danger to be avoided. These data also suggest a split between professional and managerial stakeholders around how model selection decisions would be made. Managerial firmness and disinclination towards compromise raises suspicions for senior clinicians:

‘There was no evidence at all behind that sort of figure or that sort of, that mathematics. We came up with what we thought was a more appropriate model for London. They then disappeared into a huddle and out of it came the fact that we’re going with eight. And, you know, that’s exactly what Darzi said. And my view was that it was likely that actually they felt that they couldn’t go against what Darzi had said, that they felt that they have to match the model that he described in his vision for London.’

Reference 46; Doctor 1, Clinical Expert Panel

Here professional resentment at managerial power appears to be manifested '*they then disappeared into a huddle*'. This is in contrast to the sense of shared values expressed by stakeholders earlier in this chapter. It is significant that the official documents emphasise the centrality of clinical evidence behind the decisions around the formulation of the London model, but the interview data down plays the validity of this evidence – indeed – counter examples are offered and the centrality of work force and control issues are emphasised. The dissatisfaction expressed by clinical leaders with the model and its 'management ownership' is emphasised. This nascent split between professionals and managers becomes more pronounced in the following chapter which documents the fractious issue of site selection for HASUs and SUs across London.

5.5 Summary

In this chapter it has been suggested that there were two important 'shifts' in the fields of visibility heralded by the London stroke care reconfiguration. Firstly, there was a move to interpret stroke performance in an international context and to present the state of health care in London also in an international context. By demonstrating that better outcomes for stroke are possible in other countries, stroke care implicitly became a problem amenable to human action (Stone, 1989). The second key shift, closely aligned with the first, is to present stroke outcomes across the city in markedly 'biopolitical' (Foucault, 2007) terms. Stroke care was made more high profile and presented as a pan-London issue in statistical terms for political effect. Rather than focusing merely on institutional level data to show that site A treats stroke

effectively, whilst site B does not, the problematisation heralded by Darzi created a context in which stroke care becomes a *London issue*.

Thus the types of evidence used to problematise stroke in London in this way at this time were particular and worthy of consideration. Statistically significant, scientific evidence of international best practice was used to highlight London's deficiencies. Epidemiological evidence drawing upon aggregated data was used to problematise stroke care in London. These forms of evidence are powerful because they had high levels of epistemic legitimacy for both senior academic clinicians and senior strategic health care managers and commissioners. These were used to highlight current deficiencies, illuminate potential solutions, and point to verifiable 'regimes of government' (Dean, 2010) to assure that performance can be measured (Noordegraaf and Abma, 2003). This biopolitical frame simultaneously captures the population *and* the professions delivering stroke care, whilst making subjects of both to this reconfigured stroke Discourse.

The techniques of government used to pursue these changes were linked to increased measurement (Power, 1999; Newman, 2001) and an attempt to reduce ambiguity (Noordegraaf and Abma, 2003) around the potentialities to treat stroke. The RCP NSSA was cited as a key force in the identification of stroke care variation. It has been suggested that stroke was problematised along two dimensions: firstly, an ethical dimension with implications for the subjectivities of professionals; secondly, an economic or efficiency dimension. In this chapter, the importance of professional leadership to the problematisation of London stroke care has been introduced along with the themes of standardisation (Timmermans and Berg, 2003) of care and 'calculability' (Dean, 2010; Miller and Rose

1992). These important themes will be developed further in the following empirical chapters. The issue of calculability has two different ‘power’ implications in how stroke in London was ‘problematised’. Firstly, it establishes medical dominance over nursing and therapy professional groups in jurisdictional terms (Abbott, 1988); secondly, it heralds an effective utilisation of what might be considered a managerialist discourse for all staff, including medical staff (Osborne, 1993). This emphasises an interventionist role for management (Ferlie et al, 1996). It also highlights intra-professional distinctions –as hybrid clinical-managerial leaders at pan London, and regional network levels assume new roles with distinct implications for professional power dynamics which are complicated and nuanced. The ‘problematisation’ of stroke care prompts the organisational barriers faced by stroke specialists to be highlighted and subsequently dismantled – this increases power and significance for these specialists in significant ways – they get clinical priority status within the hospital (Pickard, 2010) which is highly significant and to be explored further in later chapters.

It was finally shown how a consensus was built between key strategic managers, clinical leaders, ‘independent stakeholders’ and hospital staff around a new coherent episteme of evidence based stroke care for London – the contingent, and historicist (Bevir, 2010) nature of which was remarked upon. The following chapters will explore these issues further both at a pan-London level and with a micro-level hospital unit focus.

Chapter VI

Designing the solution

6.1 Introduction

The previous chapter focused on how stroke services were conceptualised as a London-wide problem. The forging of a shared understanding at the pan-London, or macro-level around stroke as an evidence based acute clinical speciality, requiring a standardised response from the capital's hospitals was discussed with data to show how consensus amongst stakeholders was encouraged. Sections 5.1 and 5.2 of the previous chapter highlighted the compatibility of professional and managerial goals related to the ways in which stroke care was problematised and service standardisation was prioritised. Section 5.3 however examined some inter-professional tensions related to the prioritisation of medical evidence over AHP evidence, and also highlighted the contingent nature of the evidence around the different possible models of delivery proposed to deliver reformed stroke care which pointed towards some professional dissatisfaction with SHA managers' firmness around the designation of the London model (see reference 46) .

The key aim of this chapter is to chart how the regimes of practice (Dean, 2010) were developed to 'solve' the 'problem' of London stroke care as designated in the previous chapter. This chapter focuses on how the SHA management team designed and legitimated the key organisational tenets of the London model of reconfigured stroke care. Section 6.1 discusses the bid and evaluation process for Hyper Acute Stroke Unit (HASU) services and

how the competing criteria of service quality and patient access developed into what is termed here as the ‘site selection controversy’ which again highlighted disparities between professional and management communities hinted at in section 5.3. Sections 6.2 and 6.3 discuss how managerial and professional goals were effectively realigned following the site selection phase to focus on controlling the delivery of the new model of stroke care. Section 6.2 focuses on how the new regime of audit developed through the selection phase and into the implementation phase of the programme and discusses the role of measurement in achieving standardised services. Section 6.3 introduces the concept of ‘interventional commissioning’ and highlights the active role taken by managers and professionals to achieve improved standards across London’s new stroke service providers.

Three data sources are drawn upon in this chapter. The first is documentary evidence including that produced by the Health care for London Stroke Project Team. The team published a large amount of data as part of the reconfiguration including drafts and final copies of the strategy, appendices of performance standards, service specifications, inequality assessments, public consultation documents and responses, commissioning responsibilities, economic data and also guidance for Trusts in the bidding processes to become a HASU, SU and TIA service provider. These documents in effect establish the ‘rules of the game’ for those taking part in the reconfiguration and the variety of considerations undertaken by the various panels and teams. In addition, the analysis is also informed by the meetings minutes from the Joint Committee of Primary Care Trusts (JCPCT) and the Joint Health Overview and Scrutiny Committee (JHOSC) – [the latter of which are made up of local councillors] and power point presentations of senior managers delivered to these groups. These documents paint an ‘official picture’ of publicly accountable bodies charged with overseeing the actions of the SHA in its delivery of Stroke (and Trauma) reconfigurations in London. These

documentary sources are used to establish the formal processes and interpretation(s) of the bid procedures. Secondly, the chapter draws extensively on the interview data of those stakeholders involved at senior and advisory levels across the stroke project board, clinical advisory panel, and commissioning and finance panels. The third data source is observational data produced through attendance at pan-London Stroke Clinical Advisory Group (CAG) meetings over a two year period which detail how stroke leaders oversaw implementation of the new regimes of government at a pan-London level – how they interpreted the data they were collecting, encouraged further data collection and attempted to guide and firmly establish the new stroke care episteme in the city’s HASUs and SUs.

6.2 Section 1: The site selection process

Having discussed how the London HASU model was selected in section 5.3, in this section the focus turns to how the sites to host the 8 HASUs, 24 SUs and 24 TIA services were chosen. Firstly, the official process will be described, drawing on Health care for London documentation. Analytically, attention will be paid to the forms and types of evidence used to measure the performance of different London units on the one hand, and arguments over the best way to distribute these units in the reconfigured model on the other. The technical implications of these processes will also be discussed as interview data is introduced to illuminate how the resultant issues were managed and interpreted.

All London hospitals wishing to be considered for the status of; ‘Stroke Centre’ (providing HASU and SU services), ‘Stroke Unit’ (providing acute inpatient rehabilitation) and/or TIA

services (providing rapid diagnostic assessments and access to specialists for high-risk patients following a TIA) were invited to submit ‘an expression of interest bid’ by mid October 2008 (Appendix 4, Health care for London, Acute Stroke Services Designation, *Overview of designation process*, 2008g p2). It is the site selection process around the first of these ‘Stroke Centres’ with which this chapter is concerned. A key document produced by Health care for London is Appendix 7: Acute Stroke Services Designation, *Evaluation process* (2008h) and from this document there are two important graphics which highlight the key evaluative processes. They are reproduced below in figures 10 and 11:

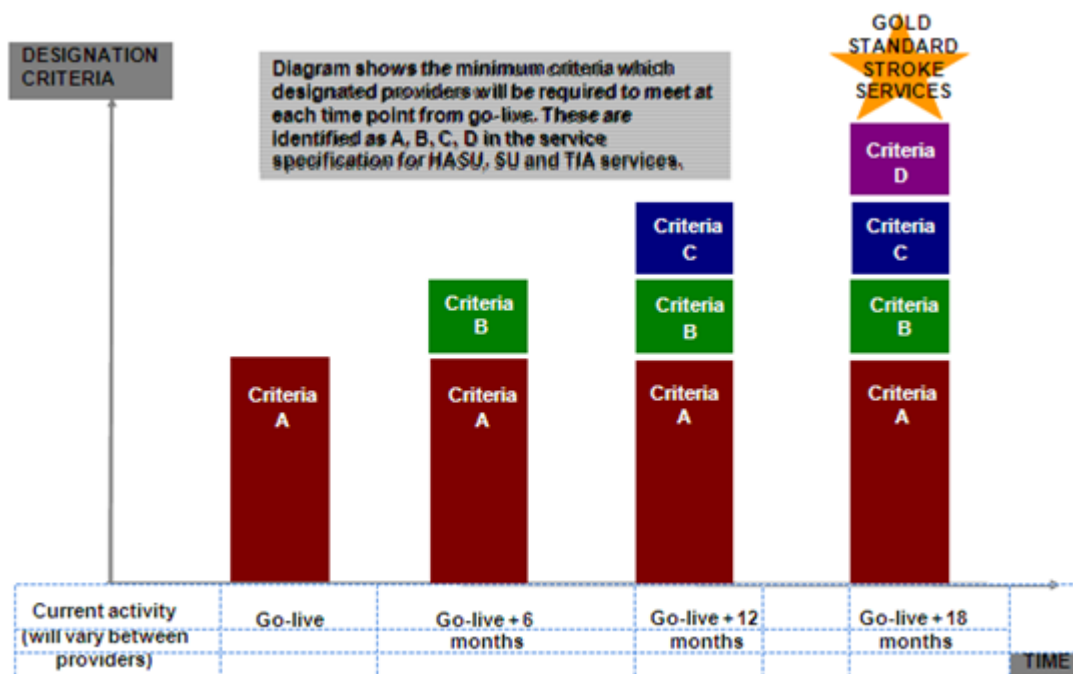


Figure 10: ‘Staged implementation of designation criteria’ (NHS London, 2008i)

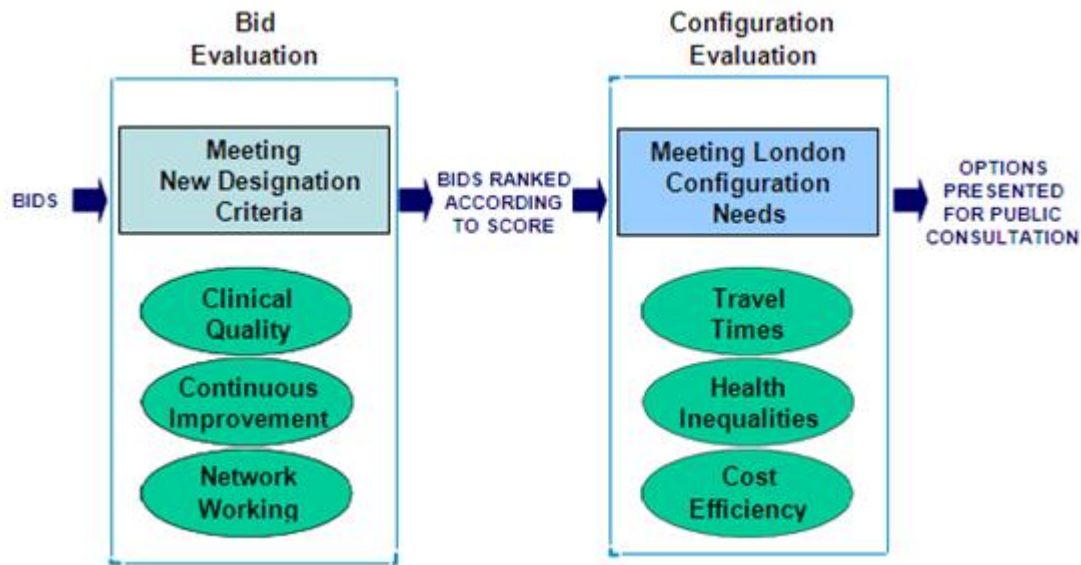


Figure 11: ‘Bid and configuration evaluation process’ (NHS London, 2008i)

With reference to figure 10 above, the details of the respective ABCD criteria are published in Health care for London, Appendix 6.1: Acute Stroke Services Designation, *Designation criteria for provision of a HASU service* (NHS London 2008i). It is worth highlighting two factors with reference to the standards. Firstly, they correlate with the bid evaluation box displayed in figure 11; they refer to clinical quality, continuous improvement and network working and they require either evidence of current attainment (e.g. via audit data) or evidence of management plans to achieve attainment in the future. Secondly, they are relatively ‘objective’ measures and relate to individual institutions. This means that the project team could evaluate both the quality of current services in each bidding hospital and the level of commitment to improving future services secured by local level management. Therefore levels of current performance and commitment to improving future performance were opened to the gaze of commissioners and SHA executives in more detail than ever before.

The effects of this are exemplified by *Tonge hospital* in particular. This hospital has traditionally been a creditable performer in terms of stroke performance as validated by RCP data and was geographically well placed to host a HASU service (as one of the largest and most clinically comprehensive Trusts in its respective sector). However, stroke service development had been *clinically* led by professional staff and developed in conjunction with medical, nursing and therapy teams based in hospital and community services with very little *general management* involvement over a number of years. By common consensus, this hospital submitted a very poor bid which according to both professional and managerial informants was not considered to reflect the true standard of current and potential clinical care which the trust was capable of delivering:

‘[Management arrangements for stroke] just hadn’t kept pace with [clinical team development] at all. So that was painfully apparent in the bid process. And it was picked up on explicitly that it was very clear that management was not supporting stroke adequately here.’

Reference 47; Doctor 2, Clinical Expert Panel

This particular Trust was invited to re-submit its bid by NHS London (and was successful). Technically specific managerial skills were needed to produce successful bids and provide assurance to commissioners that the proposed increased funding would be spent adequately. Without strategic coherence around how the London standards were to be met, individual stroke services struggled to navigate the bid process. The bid process invited the Trusts to

demonstrate that they took the management of stroke services seriously and were willing to invest the time and skills into ongoing planning of stroke services – which hitherto had been rather rare at some Trusts. It also committed the Trusts in writing to deliver standardised care to an agreed specification moving forward which was an important factor in the reconfigured London model.

By demonstrating how they meet the new designation criteria, Trusts were required to provide plans that detailed how new staff members would be recruited, trained and appraised; how emergency and radiology departments would link up with HASUs and prioritise stroke patients; how discharge systems would be devised to repatriate stroke patients to SUs closer to their own homes following the first 72 hours in the HASU. These are organisational competencies and the policies devised to achieve them were produced for external scrutiny. The practice of making this all explicit in submitted documentation was a *new* phenomenon in stroke services. It premised the new reconfigured regime of government for stroke care in London – a ‘managerialised’, standardised and specialised service meeting commissioner devised criteria and demonstrating ongoing achievements. Performance was to be monitored and measured in new ways and to new extents.

The ABCD standards provided ‘calculability’ (Dean, 2010) and produced scores for the bids of the different trusts and were in themselves uncontroversial to both professional and managerial expert communities. Theoretically the standards allowed the independent expert panel and JCPCT to make evidence based decisions about which Trusts either currently did, or had demonstrated the potential ability to provide stroke services which would meet the designated criteria in the future. They were based on *quality*. The problems arose when the

quality scores of each Trusts bid evaluation were modified by the requirements of the configuration evaluation (see second part of figure 11 above). The three key criteria here were; travel times, health inequalities and cost efficiency. These criteria are based largely on *access*. They proved to be highly controversial, and seemingly more subjective than the bid evaluation criteria. This tension between quality and access as key components in the criteria around the site selection for the HASUs is now enunciated in more detail. The thesis now focuses on how the configuration evaluation process opened up the strategic goals of the SHA to the gaze of London's clinical stroke community – with controversial repercussions. This section begins with a discussion around how and why '*eight became the magic number*' for HASU sites.

It is possible to take an evidence based approach to the bid evaluation process in which stated criteria were linked to clinical quality and organisational commitments. These elements may be measured numerically and ranked from highest quality to lowest quality bids. It is also possible to take an evidence based approach to the configuration process based around travel times, health inequalities and cost efficiency. Crucially however, the criteria for evaluating health inequalities and cost efficiency remain relatively obscured in both the Health Care for London literature aimed at the general public, and the guidance documentation produced for providers involved in the bidding process. The ambiguity behind these concepts and how they were to be applied was highly significant: they were defined and evaluated by strategic managers rather than professionals. It was recognised at an early point that this may be problematic:

‘[I]f you put quality criteria [first], you get one group of eight [hospital sites suitable for HASU care]. If you put access criteria [first], you get a different group. So making the best of those two was difficult and required adjustments to both.’

Reference 48; SHA Manager 1

The two different forms of evidence and ranking criteria clash – necessitating ‘adjustments’ to either the model itself or the evaluation criteria. This was the first key problem which those leading the selection process encountered. The apparent rationality of the two separate criteria helped to depoliticise decision making gaining legitimacy from professionals and Trust managers – hence the consensus behind the process for selecting the sites. However, the ‘adjustments’ made by the SHA were necessarily *value* based rather than *evidence* based. These ultimately required *ex post* interventions from SHA decision makers. Despite the lack of strong clinical evidence behind the 8 site HASU model (as established in the previous chapter), senior SHA managers were determined not to deviate from it. However, they did have reasons for this:

‘[M]y attitude to it at the time was if we don’t dig our heels in and say it’s eight, I’m not interested at all unless it’s eight, it will end up being fifteen, it won’t end up being nine... [I]f we’re not careful, from that we’ll get a mushrooming of numbers, then we won’t have the results that we’re looking for. So the answer’s eight. So that was top down, one size fits all. And the reason for that was to prevent the traditional London solution of saying, ‘Well we’ll have both.’’

Reference 49, SHA Manager 1

This demonstrates that the decision to robustly maintain the commitment to the 8 site HASU model was not based solely on clinical evidence but rather, it represented a management judgement based on a determination to avoid the mistakes of prior reconfigurations. Rather than clinical evidence, it was strategic management judgement that ensured the selected model did not become ‘watered down’ by the traditional institutional interests that had dominated London health care planning. The approach of the SHA was not consensual or deliberative around this question of site numbers, but firm and dictatorial.

A review of the consultation responses received by members of Parliament and local councils is instructive here. Predictably perhaps, those London MPs whose constituencies were granted a HASU as part of the proposed model were in favour of new configuration whilst those who did not were quicker to cite problems with either the evidence behind the model, the number of HASUs or indeed the consultation process or the work of NHS London more generally – the same was true of councils – reflecting an understandable desire to protect local establishments (NHS London, 2011a).

A significant piece of evidence related to how the LAS might perform in relation to different hospital configurations. There is a strong evidence base that the sooner potential stroke patients are delivered to hospital following a stroke and assessed for eligibility for thrombolysis treatment then the more likely that treatment is to be effective (Lyden, 2008). For this reason, a clear criterion of the configuration evaluation was for all Londoners to be

within 30 minutes of a HASU (in a blue lighted ambulance). A good deal of modelling work was produced by the London Ambulance Service (LAS), however this was equivocal:

‘[T]he LAS could do virtually anything. The problem was not the LAS, the problem was not timing, the problem was public acceptance of any decisions’

Reference 50, Stroke Charity Representative 2

This is significant in that the first aspect of the configuration evaluation criteria (travel times) may not be definitive. Therefore, in reality, discussions around ‘access’ were about more than evidence based ‘emergency’ criteria – they were about redistributing resources and services for strategic ends – and crucially, this was an implicit rather than explicit commitment of the SHA which had serious implications for the ‘jam’ in London’s doughnut:

‘So the history of London, as you know, is that, in fact a doughnut was what it was described as. So what’s happened in London is basically the jam where all the services were, and round the edge of the doughnut where all the population was, there was very little. So what we needed to do was have services around the edge of the doughnut and less jam in the middle. Quite logical, except for the services on the edge, quite challenging, some of them, in terms of getting them to where they needed to be... And then the one in the jam, obviously [central London hospital unsuccessful in securing HASU status] very world leading edge services, they’d been really instrumental in moving stroke forward etc. etc. and we were looking closing some of those down’

Reference 51, Network Director 3, Commissioning and Finance Panel

Problematically, the services in the centre historically tended to be of a higher standard than those at the periphery. The political reality created by the establishment of a powerful central London SHA for the first time legitimated by the Darzi review meant there was a commissioner consensus to move services from the centre and the traditional powerful London teaching hospitals out to less central locations. Nevertheless, as the following quote demonstrates this commitment was implicit rather than explicit:

‘We didn’t set out to close down specific hyper acute units, but it was a likely outcome of the process that some people who had been providing hyper acute care wouldn’t subsequently because we were being very deliberative about the location in order to meet the 30 minute access time, we needed people – so that was also innovative. So in London at least there’s a long history that we have excellent teaching hospitals in the centre of town and not such excellent hospitals around the rim. But most of our population lives round the rim and most of the strokes happen around the rim, because that’s where the older population is. And it was a *deliberate commissioner decision* that we needed to have hyper acute care round the rim and not just in the middle.’ (Emphasis added)

Reference 52; SHA project manager 2

The SHA led the agenda around shifting resources and expertise to the rim rather than the middle. This approach clearly had implications for staff working in high performing central

units in the centre that faced down-grading following the reconfiguration. Significantly the evidence based Discourse cited above around the 30 minute access times is questionable. Reference 52 highlights how a strategic management goal to have ‘hyper acute care around the rim and not just in the middle’ used the Discourse of evidence based decision making by explicitly linking these decisions to ‘30 minute access time’ but as reference 50 highlights – the LAS modelling evidence did not necessarily back this decision up. Therefore, although, as claimed, the SHA ‘didn’t set out to close down specific hyper acute units’ they in effect chose to do so. The criteria for these decisions were based on management judgements about the configuration of London’s hospitals going forward but the language used to justify these judgements draws on clinically influenced Discourse and is presented in neutral, pragmatic and evidence based terms.

There are significant implications which follow from this; in epistemic terms, commissioners used the Discourse of evidence based decision making to depoliticise and justify management decisions – this highlights how arguments grounded in the language of EBHC can be used by managers (Mykhalovskiy and Weir, 2004). It hints at the skill commissioners may have developed in utilising what was originally a primarily clinical or professional Discourse. The use of this Discourse however led to accusations that the independence of those tasked to make the final decisions, and the criteria they were empowered to use was counter to that of the published process which in turn alienated some professionals – particularly those involved in the reconfiguration process with links to sites to be downgraded. There was a commitment shared by senior SHA managers to move some stroke specialist services away from central London providers towards hospitals on the periphery. Traditionally, the powerful central London providers (teaching hospitals with academic links and charitable funds) had been in an advantageous position to develop the best services:

‘[T]eaching hospitals are richer, they have more money and therefore they can afford to develop good services partly because they have the funding base, but also partly because they, a lot of them were academic centres. So, for example, *Arnott hospital* and *Edwards hospital* both have academic departments with an interest in stroke and therefore those academics have built up their departments to be very strong. *Morris hospital* didn’t have an academic department at the time, but they had been in receipt of a huge amount of money from charitable funds to build up their stroke service. So they had a fantastic Rolls Royce service because they got two million pounds from the League of Friends. Hospitals in the periphery simply don’t have access either to the academic departments or to that level of funding.’

Reference 53; Doctor 3, *Kenworthy hospital* and Clinical Advisory Group

Therefore given the SHA’s goal to standardise care and reduce health inequalities, there was a need to consider access to services (not just for patients as emergencies, but also for families and carers to visit relatives and friends in hospital) and maintain a firm position in the face of opposition from central London providers. The decision of the SHA to couch such decisions in EBHC Discourse may be interpreted as an attempt to depoliticise contentious decisions – however it may appear to have created a rift between some of the leading professionals and the senior SHA managers which threatened to derail the reconfiguration.

So far this chapter has demonstrated the tensions between the bid criteria and the configuration criteria and the conflicting evidence based and value based judgements

required to reconcile the two. There were two further issues related to the bid process which complicated matters further. This chapter now focuses on how these issues became apparent; and the management techniques used to resolve them. There was a rather antagonistic fall-out from this that led to claims of ‘goalpost shifting’ from a number of senior professionals involved in the process as the clinical expert/strategic management divide grew through this difficult part of the reconfiguration.

All the relevant Trusts submitted their bids in late 2008. These were independently ranked by an external (non-London based) clinical expert group. However, there was a problem with the results:

‘So some [independent experts] from York, some from Bournemouth, that came together on specific days and went through all of the bids, and they scored them based on quality and various other criteria. It was again very robust. And at the end of that we ended up with, you know, a real kind of list, rank list of providers for each of those three packages. The problem that then raised its head was that actually sometimes due to the quality of the bid process within each Trust. Some of the Trusts that clearly provided good services had provided terrible bids. And the other problem was when you mapped the services geographically, all of the good bids and all of the good services were in the middle hole of the doughnut of London.’

Reference 54; Stroke Nurse Specialist, Clinical Expert Panel

‘[W]hat came out was a result which caught all of us by surprise frankly. And for which we hadn’t got a plan, which was that no units in [a specific geographical] third of the city passed either the hyper acute or the stroke unit assessment. And at that point therefore we had to adopt a different model of deciding which units would be in and which units would be out.’

Reference 55; Project Manager 2, SHA

The bid evaluation scoring system designed by the clinical and managerial leaders of the project to ‘score’ bids failed to achieve ‘acceptable’ results for stakeholders. Despite the months of planning and deliberation, it proved problematic to capture the requisite data to demonstrate in evidence based terms which London hospitals were currently or prospectively capable of providing stroke care at the level demanded by the new London model. Depending on one’s view, the results of the bid configuration were either unreliable and highlighted the technical difficulties in accounting for the complexities of measuring performance using the selected metrics; or, demonstrated that the quality of London stroke care was even lower than expected across large swathes of the city – requiring a different approach to the problem. Either way, the project team had stumbled into unexpected territory – meeting the minimum standards presented more of a challenge than was presupposed and the strategic goal of spreading the jam of the London doughnut out towards the periphery appeared more difficult than the SHA leadership had anticipated. At this point the senior management team did indeed *‘adopt a different model of deciding which units would be in and which units would be out.’*

‘You know, there would have been a concern about that in [a specific area of] London with the highest deprived population not getting a service. So there was, where do people live who have strokes? And can they get there in thirty minutes? There was, ‘Let’s put stroke with trauma.’ And then, what, from people’s perception of London, feels right, like the right location.’

Reference 56; SHA Manager 2

There is a strong consensus generated from the interview data that between the collation of the scores for individual bids being evaluated and the proposed reconfiguration being put out to public consultation and then ultimately the JCPCT - at least two *ex post* considerations were added to the model which guided the decision making process. The first was to co-locate HASUs with specialised trauma services (which were undergoing a simultaneous reconfiguration likewise prompted by the Darzi review). The second was to co-locate HASUs with specialist neuroscience services. The first point to state here is that there appears to be little compelling clinical evidence to justify either of these co-location decisions. The second point is to reflect on the language used by the SHA manager in reference 56 – especially at the end of her comments – she talks of ‘people’s perception[s]’ of what ‘feels right’. These are subjective value judgement terms based on sentiment, or strategy rather than science. These are *ex post* quasi-evidence based decisions (in that they appear to be based on intuitively sensible criteria) which ultimately proved acceptable to the JCPCT which agreed the SHA recommendations, but alienated a number of stroke care professionals hitherto committed to the bid and configuration processes, some of whom stood to lose out by having their own successful stroke services down-graded:

‘[T]he big controversy at the time was around HASUs, and actually it had gone from being a really transparent, really robust process that everyone believed in, to being a bit make-it-up-as-you-go-along and find evidence where you need it because it justifies your political end basically. So it suddenly went from being very transparent to being very suspicious both for us and for a lot of other units, even though they had neurosciences on site.’

Reference 57; Stroke Nurse Specialist, Clinical Expert Panel

For some clinicians involved at a senior level, a strong emphasis was placed on the commitment to the evidence based criteria in the bid evaluation process whilst they suspected that for the SHA management it was little more than rhetoric, or expediency, and this caused consternation:

‘[The SHA Chair was] essentially saying, ‘Well we’re now going to change the rules about accreditation.’ So it wasn’t based on evidence. In other words, their quality’

Reference 58; Doctor 5, Clinical Expert Panel

‘[It was] like a rabbit out of a hat and it really was that startling – and I recollected being at the meeting in which decisions were taken. The message was delivered from on high, by which I took to be [the SHA Chair], that there has to be co-location, which significantly advantaged one of the hospitals and disadvantaged another’

Reference 59; Stroke Charity representative 2, Clinical Expert Panel

This nominally ‘independent’ voice in the process who stated that he had no institutional axe to grind suggests in reference 59 that the SHA Chair unexpectedly changed the selection criteria in order to justify a strategic decision with relation to HASU location. Rather than evidence guiding policy, this appears to be policy guiding evidence. The legitimacy gained by framing the reconfiguration in evidence based terms was endangered when senior SHA management began to use the discourse of evidence based decision making to justify decisions which professionals rejected as having a firm clinical evidence base:

‘So some of the decisions that the JCPCT made seemed to be around which units had neurosciences on site. And yet when the clinical group had agreed the clinical standards based on the evidence, we decided not to link neurosciences’.

Reference 60; Stroke Nurse Specialist, Clinical Expert Panel

This quote is intriguing in epistemological terms as it shows the autonomy the clinical panel enjoyed in drawing up the agreed clinical standards in the first place ‘*we decided not to link neurosciences*’ highlighting the constructed nature of scientific knowledge and the dominant position of experts in validating regimes of knowledge and interpreting evidence. In technical terms, the power of the senior management community is highlighted by how they were able to interpret and present evidence to the JCPCT by emphasising the importance of on-site neuroscience facilities regardless of the *a priori* position of the clinical experts. A justification is given for the co-location of HASU and Trauma services in the National Clinical Advisory Team (NCAT) report of 2009:

‘It was also felt that there should be a HASU at each proposed major trauma site to maximise the use of clinical expertise (particularly in the neurosciences) and investigative facilities. NCAT endorses this proposal and believes pursuing it will deliver significant benefits to patients.’

Reference 61(NCAT review, 2009; p2)

Some SHA managers reject these accusations of ‘goalpost shifting’ - they assert that this perception is linked to communication issues and the pace of change:

‘The discussion about should we go for this co-location thing, was done at the beginning. And I think the mistake we probably made was in thinking that we could follow it through to the same pace.’

Reference 62; SHA Manager 1

‘I don’t think the goalposts were moved. I think what happened was that, it wasn’t explained clearly enough at the beginning. A bid is not an assurity that you’re going to get it. It’s a bid; it doesn’t mean you’re going to get it.’

Reference 63; Network Director 2

There is an implication (from some SHA management respondents) in the interview data that those who complained about the legitimacy of the site selection process were doing so out of a sense of injustice at the down-grading of stroke services at their own particular respective site(s) and that they were merely demonstrating institutional loyalty (see reference 71). The sentiments of a leading clinician whose hyper-acute service was down-graded are expressed below:

‘I felt personally angry and bitter about the fact that a unit that had been working highly effectively was being closed. And again, I mean, just it seemed to me to be nonsense when you’re trying to build capacity within the capital to – and there’s very limited capacity starting. You don’t get rid of the things which are working well in the hope that you’re going to grow something good elsewhere.’

Reference 64, Doctor 1, Clinical Expert Panel

There is a painful irony for key members of staff working at this site – due to the strategic goals of managers concerned with reducing the concentration of services in the centre and spreading services out to the periphery of the city – their highly successful stroke services were down-graded in the interests of stroke care throughout the city as a whole. However, there was a symbolic element to this SHA decision; it highlighted that no service (or provider) was ‘above’ any other, and that biopolitical requirements of the city were prioritised over institutional interests. The dangers linked to the down-grading of high performing stroke units however were that the skills of those working at these hospitals

would be potentially lost. It also alienated and angered some professionals who had served on the clinical expert panel:

‘And I remember at one point, because everyone else was being very polite, why the hell have we wasted six bloody months? You might as well have said ‘I want it there, there and there, and we’ll just build the building and train the people up and put them in.’ But as [we] and everyone else said, ‘It does not take three months to train somebody, it can take ten years to build up a unit.’’

Reference 65, Doctor 5, Clinical Expert Panel

This sense of disillusionment runs through many of the interviews with clinical expert panel members and expresses the sentiment that if the process was not to be based on evidence, then the bid evaluation process was just some form of ‘charade’. The problem with the approach outlined in reference 65 of course is that such an unsubtly dictatorial approach would have been likely to have faced massive opposition and lacked the requisite legitimacy to deliver a realistic degree of change.

In the previous chapter, it was shown that the specifically ‘evidence based’ way that stroke was problematised engendered clinical legitimacy for the proposed remit of the reconfiguration. It was also shown that medical evidence was prioritised above other forms of evidence (specifically therapies evidence). The clinical legitimacy of the reconfiguration enabled SHA managers to depoliticise the discourse around the need for service redesign (which would impact upon different institutions) in more or less positive ways in order to

minimise the kind of resistance that stymied prior attempts to rationalise London health care delivery. Furthermore, the promulgation of medical knowledge enabled medical leaders to exert key influence in the redesign.

A key concern of this chapter has been to focus on the relationship between senior SHA managers and senior stroke professionals and analyse how and why their respective goals converged around the bid evaluation criteria whilst they diverged around the configuration evaluation criteria and present this within the frame of ‘evidence based’ decision making. The aim of this section is to reflect upon the point at which the clinical-managerial consensus broke down in order to analyse what this suggests about the relationships amongst and between these elite level decision makers. This is why the metaphor of the ‘shifting goalposts’ is so pertinent. The most senior manager responsible for leading the project below describes the point where she was instructed by her own superiors within the SHA to ‘shift the goalposts’ in relation to linking the HASU location with that of the Trauma centres:

‘Then the third problem that we had... during this process [is the SHA] NHS London. So where you have major trauma, you had to have HASU. And we hadn’t said that at any stage, so neither major trauma nor HASU had said this. The meeting we had, where we were told, ‘You’ve got,’ me and [the person] who led for trauma, we were told, ‘You’ve got to make it work.’ There was no, there was no give. This was an instruction... Yes and we tried arguing back and they said, ‘No you’ve got to do it.’ So we go, ‘Okay.’... It was a right bugger, a right bugger. So absolutely the goalpost[s shifted].’

Reference 66; SHA Manager 2

Crucially, in terms of management style, although this manager ‘tried arguing back’ senior SHA management left her and her Trauma colleague with no opportunity to dissent. She was clearly unhappy about the decision and very open about the *ex post* nature of the decision but resolved to follow the SHA orders. Highly significantly, there was a requirement for the project team to justify this decision after the fact and produce evidence to demonstrate why this *ex post* decision was legitimate:

‘But we were asked to look at was there an evidence base which actually could be used to justify for frankly the decision that those places that had major trauma also had to have a hyper acute unit in. And actually I think the answer was frankly, ‘no,’ although there were lots of characteristics about the kind of hospital you would need for each of them that would be similar... So was there an evidence base that said these two must be in the same place as each other? No, there are no interdependencies really between hyper acute stroke care and major trauma care’

Reference 67; Project Manager 2, SHA

‘So we put together, yes we put together an argument as to why you had to have trauma and stroke together. It took a bit of time because you kept on having to say ‘Well there is no argument.’...we’d produce the piece of paper as to why it had to be together... *If someone had said they’d got to be separate, we could have forced it through as well.*’ (Emphasis added)

Reference 68; SHA Manager 2

References 67 and 68 explicitly highlight how senior project managers were asked to find evidence to justify an already made strategic decision (as opposed to using evidence to guide strategy). Both managers in references 67 and 68 concluded that there existed no such evidence but nevertheless ‘put an argument together’ to suggest that there was. Reference 68 above is very stark in terms of the dominant position held by the SHA and the confidence it felt it had in its abilities to lead change regardless of the evidence and the opposition.

Appendix 1 of the *Decision making processes and criteria to be used by the JCPCT to agree future service provision arrangements* advises in section 5.3, under the heading ‘Strategic Coherence:’

‘We recommend that a configuration will be approved which:

- *enables a co-location of hyper acute stroke units with major trauma centres.*
- *ensures all major trauma and hyper acute stroke services are located on hospital sites which could be significant providers of specialist acute services (major acute hospitals) in the future.’*

Reference 69 (NHS London, 2011c, App 1; p4)

There is a clear irony in the paradoxical situation of managers being asked to construct an evidence based case to justify a key tenet of an ‘evidence based’ reconfiguration for which no strong evidence exists. At least one of these managers feels that this is ‘*a right bugger*’ but

goes along with it and suggests that managerially it would have been possible to construct a case for the polar opposite position: *‘If someone had said they’d got to be separate, we could have forced it through as well.’* There are two implications that might be drawn here – one of which highlights the strength of the evidence based movement and extent to which evidence based Discourse has permeated health care policy making and a second which hints at the weakness of the movement. Firstly, decisions appear to be more legitimate when framed in ‘evidence based’ language and accompanied by documentation and managers are expected to provide this for their strategic decisions. Secondly though, the power of evidence based Discourse is susceptible to being undermined and exploited by managers in order to further strategic or local political goals by presenting decisions as evidence based when no evidence for them in fact exists. This furthermore highlights that for all the documentation produced by the project team around criteria for bids, ability to reach data set standards and use of evidence based Discourse, management consultant derived ‘weighted bid’ standards, the involvement of independent expert panels, Joint Health Overview Scrutiny Committees, the JCPCT and public consultation exercises; when it came to the most strategically delicate decisions:

‘The power lay very strongly within a cohort of two or three people within the strategic health authority’.

Reference 70; Doctor 1, Clinical Expert Panel

The implications of this power tussle are not straightforward. Those who felt most aggrieved by the process are those whose own services were down-graded in the reconfiguration.

Indeed it might be argued that part of the role of the cohort of two or three people within the SHA was to dissipate power throughout the capital by challenging the traditional dominance of one of the capital's most powerful hospitals. Once more this points towards a biopolitical (Foucault, 2007) outlook for the SHA:

'I think there were some people relatively in the centre of it who don't understand cabinet responsibility actually. And so, you know, you join a cabinet knowing that you input into the decisions of that cabinet. But they're not always unanimous. And actually if, if at the end, if at the end of the day you're not prepared to accept the cabinet view for staff, then you have to leave really. And I think some people, slightly naively, thought that, you know, in some ways their job in the cabinet was to bat for their organisation, not to, not to bat for 12,000 stroke patients in London. And actually the job is to bat for 12,000 stroke patients in London.'

Reference 71; Doctor/Manager 1, Stroke Leadership team

This quote captures the sense that the reconfiguration was to a degree concerned with transforming stroke care in London in biopolitical terms with impacts for the subjectivities of clinicians who were required to think of stroke care in network, or city wide terms rather than institutionally. Whilst this goal holds attractions for the SHA, it is also understandable that institutional loyalty maintains a residual call on clinicians involved in building up successful services as they traverse stages of the reconfiguration.

The following sections of this chapter describe how consensus between the professional and managerial communities was restored in the technical delivery and implementation methods designed for the new London model of stroke care.

6.3 Section 2: The new regime of audit

The aim of this section is to analyse the technical means by which the goals of the reconfiguration were pursued at a (macro) Pan-London level. Building on the data already presented around the role of evidence in firstly; the problematisation of stroke services in London and secondly; the strategic decision making process around where to locate HASU care, this section will explore the role of evidence in the implementation of the new ‘regimes of government’ (Dean, 2010) of London stroke care. This section analyses the increased role of audit central to the reconfigured stroke service in London and its compatibility with both professional and management goals. This focus on audit is then critiqued in relation to the drive for standardisation in and of services and a concern with the ‘hard’ policy and management tools employed to achieve service standardisation.

The first point to emphasise is that prior to the reconfiguration there was no specific London data collection process for stroke care. All Trusts were obliged to return data on a bi-annual basis to the Royal College of Physicians (RCP) as part of the National Sentinel Stroke Audit (NSSA). The audit had an organisational element and a clinical element – based on a retrospective review of 60 case note histories. The NSSA ran from 1998-2010.

From 2010-12, the Stroke Improvement National Audit Programme (SINAP) replaced the NSSA. It was commissioned by the Health care Quality Improvement Partnership (HQIP) and run by the RCP Stroke Programme for the Intercollegiate Stroke Working Party (ICSWP) and endeavoured to cover all hospitals treating stroke patients with a specific focus on the first 72 hours of care. From December 2012, the Sentinel Stroke National Audit Programme (SSNAP) was established which aims to collect the relevant data that providers need to supply to comply with the NICE quality standard and Accelerating Stroke Improvement metrics and other NHS outcomes measurements. The aim is to collect a ‘minimum dataset for every stroke patient, including acute care, rehabilitation, 6-month follow-up, and outcome measures in England, Wales and Northern Ireland’ (RCP, 2014).

Stroke governance audit procedures underwent a radical change between 2010-12 as all London hospitals were mandated to record over 100 data fields electronically in real time for every single patient detailing clinical and organisational elements of their care over the first 72 hours from admission and submit these as part of the RCP Stroke Improvement National Audit Programme (SINAP). Alongside this national professionally led development extending audit, in London, there was a managerially devised London Minimum Data Set (LMDS) organisationally focused audit which monitored the ability of the new HASU and SU sites to meet the criteria against which they were now to be judged (and paid):

‘That [the decision to request data from providers] was me saying we’ve got to collect some data on this because otherwise we’re not going to know if – so the

reconfiguration made a number of assumptions, and unless we collected, started to collect data, we would have no idea as to whether or not those assumptions were right, wrong or, you know, or moderate.’

Reference 72; Network Director 1

There is a justificatory element to it – there is a desire to measure and account for change in order to demonstrate the efficacy of the new regime. The LMDS derived from a number of the key elements of the ABCD standards developed as part of the site selection process detailed in figure 10 – see also appendix B. The LMDS was an attempt to pragmatically construct a new ‘truth’ (Dean, 2010) around the accuracy of the assumptions upon which the reconfiguration was based. As the following quote from another Network Director demonstrates, although it generated dissent amongst those tasked with completing it due to its labour intensiveness, the audit regime played a central role in the reconfiguration:

‘I think it’s a very, very onerous task at the moment and it’s the one thing that they [individual units] absolutely almost throttle me over having to do it because it’s in so much detail... But that is certainly [something] that I would recommend continue. As soon as you take your eye off the ball, things will slip. And I think building in regular monitoring of quality standards is really, really important. It’s the only way that you can maintain a high quality service.’

Reference 73, Network Director 2

The quote above illuminates a number of important issues: firstly, the audit developed from its early days to require significant time and effort from the staff of each unit; secondly, the identification of the imposition of the audit lies with Network officialdom. The Director quoted in reference 73 draws on jovial yet violent language to describe how audit impacts upon the relationship between those who request and those who complete the audit data. The regime of audit was established by the Networks and leads to a potentially fraught dynamic. The third point is the most significant however and is expressed time and again by both managerial and clinical respondents – if you *take your eye off the ball, things will slip* and an ethos in which there is regular monitoring of quality standards is *the only way* that high quality services can be assured permanently. There is a deep seated fear that without constant monitoring, the gains made in stroke care may be lost and intensive audit is a crucial tool in ensuring compliance to the expressed goals of the reconfiguration.

Audit and measurement against explicit standards are at the heart of the new model. An element of this relates not merely to the ethically motivated drive for higher clinical standards in the interests of patients, but also a commitment to demonstrate value for the extra money secured from the 31 London PCTs:

‘[Y]ou have to measure them [the providers] to know whether you’ve got it [improving standards]. And on the money business, if we were going to put the money in, so actually it was an awful lot about workforce. So the way you get the standards is by getting the workforce, a) there and, b) working well. And... all that stuff, so the units going live and getting the money was all about, ‘Well do you actually have the nurses in post?’ So it got very – so, but part of the feature was the

standards, the second of which is we were going to put money in; we needed to know that we were getting value for our money. And third of which is, that we had had this audit process and [Doctor 1] had been around, so there had been people who understood that measuring things was one of the ways you drove up standards. And then we had the stroke networks who had the capacity to crawl all over people. So there were a combination of different drivers'

Reference 74; SHA Manager 2

As highlighted in the previous chapter, a key element of the reconfiguration was the increased stroke workforce across London's hospitals. A large proportion of the extra funds went to pay the wages of the new stroke specialist staff. An important focus of the new audit was therefore around justifying that these new staff members were indeed actually carrying out the roles for which the extra funding had been intended. This is significant – this element of measurement is not punitive for stroke specialist staff – rather it is potentially positive for them because it opens up the gaze of the Networks and the SHA to the staff establishment numbers on the unit – the subject of this key element of the audit is the *organisation* (represented by staff establishment numbers) rather than the performance of the stroke specialist *staff*. The second element – 'are they *working well?*' has greater disciplinary implications for unit staff clearly, but the key starting position for the nascent audit was establishing that 'nurses are in post' and that local Trust management is not reneging on the financially significant staffing assurances that were key to successful attainment of HASU and/or SU status. The third point, relating to Doctor 1 and the work he had previously done around clinical audit and standardisation points towards the increasing symbiosis between professional and managerial goals at the centre of the audit regime. The penultimate point

and in particular the language used with respect to the Networks having the '*capacity to crawl all over people*' is very stark and demonstrates the central role of the Networks in implementation from the point of view of the commissioners. The final point articulated in reference 74 is also significant in highlighting the multi-factoral nature of audit in the London context. It acts upon multiple stakeholders and is flexible enough to be interpreted and used in a multitude of ways.

Once early audit data began to highlight positive change it became an important motivational tool for senior managers vying to suffocate opposition to the model:

'And then we started to get, see some of the outcomes. Then people eventually got, you know, gathered a degree of pride in what had been achieved. And so you have like a tipping point, don't you, and think, 'Okay I'm going to oppose this; it's not going to happen. Well okay it's going to happen, I don't like it. Actually this is really good for London and it's good for patients.' And people can see that. And then once you've got that, you have a, like a domino momentum then. And then everybody wants to show people that this is working, they like to show, they like to gather the evidence and they like to show that it's working and that's where we've got to now.'

Reference 75; SHA Manager 1

Audit data was used to validate the ethical underpinnings of the reconfiguration – the new regime of practice was producing a new, better 'truth' of London's stroke services – in this context, dissent, or antipathy to the model became increasingly illogical, thus limiting

conflict (Newman, 2001). Furthermore, the onus shifted to others working in the system to match the gains made elsewhere in order to demonstrate that they too are capable of improving outcomes in a comparable manner. The LMDS and SINAP requirements merged – symbolising professional and managerial compatibility:

‘We basically suggested to the clinical advisory group that if everybody in London added these ten questions to their user defined fields, so their free bit of SINAP and everybody completed SINAP, we would be able to get all of this information. You’d all know, on a month by month basis, how you were doing against each of the quality standards that’s within your contract. You’d all be able to answer your Department of Health reporting requirements, you’d all participate in the national audit, you’d all meet your ASI [Accelerating Stroke Improvement] quality measure data requirements.’

Reference 76, Network Project Manager 3

Aided by the pan-London Stroke Clinical Advisory Group and the Networks, the LMDS was merged into the electronic reporting requirements for the new RCP SINAP audit – providers were encouraged to collect both clinical and organisational elements and respond to the multiple calls for data in one single electronic return (for every single patient) merging the requirements of separate improvement programmes. Building on the pride that the impressive early outcome measures were engendering, clinical auditors were able to radically expand the comprehensiveness of the prior RCP audit into stroke and merge the borders between data collected for management and professional rationales. This is an important step that blurred

the boundaries between professional and managerial communities as ownership of the comprehensive SINAP audit data is contested:

‘[U]p until now it’s been clinically led. But what’s happening is that the SINAP data is owned by the management, by the organisation... The organisation is now saying, ‘This is our dashboard, this is how we’re doing, these are our performance indicators.’ Commissioners are looking at it and saying, ‘Why are you not doing that?’ etc. When I had my performance review meetings monthly, we’re looking at SINAP data and why have you not done that and so on. So the measures in SINAP are clinically owned. They’re put forward by clinical groups; they’re measured by clinicians still. But it’s turning into a, something by which managers are being judged. So my general manager now, you know, she’s having the performance review meetings and she’s having to explain why we’re not meeting the door to needle target or whatever it is.’

Reference 77; Doctor 2, Clinical Expert Panel

The comprehensive nature of the SINAP audit data, its real-time nature and electronic format and rapid dissemination to various stakeholder groups represented a significant change in the management of stroke services in London. Performance was made much more visible and clinicians and managers in turn therefore became much more accountable (Timmermans and Berg, 2003). There appears to be some kind of ‘reciprocal enrolment’ (Osborne, 1993) of managers into a professional regime of government (Dean, 2010) here. Furthermore the performative language of this clinician is of note:

‘So if you believe in evidence-based medicine, as I do, then you believe that people should follow guidelines and be measured against it and get good at that... A lot of the easy things can be taken away and systematised, and I think one of the things you’ve got in a HASU is people stopped bothering with – well there are still people who try and tinker and say, ‘I always do it this way.’ But really the HASU is a production line... And there’s no time to not just follow the guidelines and get on with it. And it’s about where health services are going to have to go, because you’ve got to be more productive.’

Reference 78; Doctor 2, Clinical Expert Panel

This quote highlights a managerial ethos central to the EBHC movement – professionals must follow guidelines and produce data to demonstrate that they are doing so – clinical knowledge can be codified to the extent that the HASU becomes a *production line*. Professionals have no time to challenge established guidelines and must become more *productive*. There is a strategic element to this:

‘[W]e deliberately built in all of this from the beginning, the whole point of the Sentinel Audit, going forward, was that we believe in quality, and if you have managers being judged as well according to quality, that protects the quality from any pressure to move resources elsewhere. And stroke, in particular, is very vulnerable to that.’

Reference 79; Doctor 2, Clinical Expert Panel

This account suggests that clinical audit of stroke was designed by clinicians to ‘capture’ or ‘colonise’ (Power, 1999) Trust level management so that resources would become protected in order to establish a base level from which professionals could pursue quality outcomes in clinical care. Rather than audit being an externally imposed tool of non-clinical managers pursuing political, strategic or economic goals it appears to be more akin to a professionally led imposition of disciplinary regulation which establishes a space for clinicians to realise their ethical desire for *quality* of care for stroke patients.

Another consultant talks of a more managerially focused generation of medics using data to encourage providers to promote quality in order to serve the requirements of commissioners:

‘So you’ve got the breed of people, almost managerial people coming through, and so they were initially able to turn around and say, ‘Well actually let’s look at this, length of stay for hips, we’re going have to do better.’ PCTs and SHAs went, ‘Well actually you’re very bad in terms of value for money for this, we’ll go to another place,’ and therefore hospitals have to look at themselves in more detail and say, ‘Right, we’re not actually performing very well on this, we need to do better, how are we going to do better?’ And then that, you know, it does bring people – and clinical people, into the mix, and asking, ‘Well how can we get this better?’’

Reference 80; Doctor 5, *Kenworthy* hospital

This informant suggests there is a kind of generational shift in professional subjectivities – and that quasi-manager/doctors (or hybrids) (McGivern, 2006) are able to arm themselves

with evidence from clinical processes and push for change. This idea is reflected elsewhere in interview data and observation data – three key senior consultants who were very active in the London Stroke Clinical Advisory Group meetings were, or had been, intimately involved in the establishment and/or current running of the National Stroke Audit Programme at the Royal College of Physicians – their shared agenda related to the transformative value of audit making performance visible was relayed through the meetings and also confirmed in interview(s). In this interpretation of clinical-managerial relations, the commissioners are the potential allies of the hospital based clinicians – in league against the (non-stroke focused) Trust general managers – in effect, by using patient quality data effectively doctors may be enfranchised to use the potential threat of the commissioning of services being withdrawn to ensure a stronger voice in discussions with general managers around service delivery and resource allocation within Trusts.

There is also a practical clinical value to the enhanced data collection regime:

‘The data we gather, we – obviously about length of stay. We look at readmission rates, are they working, how many patients do we actually have readmitted – were they the TIA, stroke or other conditions in the first, in those first weeks after they’ve gone home that we’re looking at.’

Reference 81; Ward manager 2 (and nurse), *Kenworthy* hospital

Again this highlights the value to clinical and managerial staff of having increased measurement and driving improvement strategies. This also demonstrates that a key element

of clinical audit regimes being accepted and valued lies in their relevance to staff (Dixon Woods et al, 2009; Iedema and Rhodes, 2010). There is a further element to the increased audit regime however, described below by a Network Director:

‘I mean it [the London model] is sustainable but not if it’s, if it’s not monitored, people will do their own thing... But it is, you know, it’s a classic. It is a paradox because... if you’ve got that sort of central ring holding it all together, that enables people to become powerful in their own fiefdom. Whereas if they can’t report back to a central thing, who’s going to take any notice of them?’

Reference 82; Network Director 2

Greater control of professional practice through increased monitoring is essential to stop people doing ‘their own thing’. The data is reported back to a central ring – but this accountability effectively increases the power of those under surveillance. This is indeed paradoxical – whilst the problem stroke specialists faced before the reconfiguration was a lack of power and/or recognition within many London hospitals because stroke was frequently a low organisational priority, they are able to adapt to the increased surveillance regime and use this as a tool to further their agenda(s) and ensure that they are indeed taken notice of – through increased control they may experience greater freedom and influence (McKinlay and Starkey, 1998).

The onerous nature of the audit regime was aligned to an imperative of increasing the standards of poor performing Trusts in particular:

‘[I]f you replicated that [the extensiveness of SINAP] through all of the NHS, the structure of the cost to the NHS would be very different! You know, and in that sense it’s too much. But there was, there was a very clear view that, that the, particularly for those hospitals which had failed on quality, that the [push] up to get them to be a good enough was a big ask. And it wasn’t going to happen overnight. And they did need to be supported and monitored and audited through that process. So there was quite a lot of drivers for making it happen, because otherwise the standards would never arise because we’d been doing Sentinel audit for years and look what had happened.’

Reference 83; SHA Manager 2

The new surveillance regime placed burdens on Trusts in terms of ensuring data collection compliance. This is linked to an understanding that the less intensive NSSA failed to break down the barriers to effective stroke care and that for a number of previously low performing Trusts, the road to achieving care on a level produced at the highest performing Trusts would be long and rocky and a recognition that monitoring is essential to the achievement of standardised services.

A key goal of the increased audit regimes was to *standardise* care across the city. The aim of standardisation of stroke services in London was lifting low level performers (as identified by the NSSA and via the bid process) to the same levels as the city’s high level performers. This was an inevitable result of prioritising access over quality in relation to the selection of HASU sites:

‘The most controversial decision that was taken... where everybody said, ‘This is a failing hospital, their bid was useless, you know, it’s never going to work, they will never be able to provide the service to the right standard.’ And the answer is, if we don’t have one there, there’s a hell of a long way between the [closest other hospital with a HASU] and the next nearest place out [of London] somewhere. So we’ve got to make it good enough. The way we – so in the end the way we dealt with that opposition was to say, ‘We won’t give them the money and we won’t give them the designation until independently they’re evaluated as having met the standard. And that, to an extent, dealt with people’s concerns about it.’

Reference 84; SHA Manager 1

New services were commissioned on the understanding that universal quality markers would be met. Those tasked with implementing the changes had to emphasise this to the senior managers of traditionally weaker hospitals:

‘They were being commissioned on the basis of these standards being delivered. So there was some work with myself and the network director to go to particularly the poor performing Trusts and really make sure that the chief exec and senior management really understood that they would not be getting the London tariff until they achieved those standards. And they wouldn’t be designated as a providing stroke unit care until they met those standards.’

Reference 85; Stroke Nurse Specialist, Clinical Advisory Group

The target group for this message is senior hospital managers (not stroke professionals) and the argument is emotive around the needs of patients juxtaposed with the reputational and economic implications for the Trust as a whole if the standards were not met. Standardising care and uplifting the quality of services expected by historically low-level performers began to repair the ruptured relationships between SHA management and certain senior professionals whose own services at *Burridge hospital* had not been designated HASU status:

‘*Arnott hospital* was a failing Trust, poor quality, a million miles away, and you’re going to shut the wonderful services at *Burridge hospital* and rely on a crap service in *Arnott hospital*. And again in the end, what people rallied round really to do with that was to put the resources and the expertise in to *Arnott hospital* to help them meet the standard. So, [Doctor 1] as an individual, was very, very sceptical about the *Arnott hospital* - and *Burridge hospital* was his service. And he, in the end, and I mean absolutely to his credit, fantastic leadership behaviour really, to say, ‘Actually I’m going to make this work.’ He put the resources and effort in to getting *Arnott hospital* up to standard.’

Reference 86; SHA Manager 1

The above quote demonstrates strong clinical leadership and a commitment to the development of effective stroke services beyond institutional boundaries – knowledge around how to successfully achieve high standards was shared through the system and crucially, services were not accredited until fidelity to mandated specifications was demonstrated. This

was a universal requirement through the city – indeed one Network Director emphasised that it was easier to ‘do everybody rather than just select’ and importantly, it was linked to organisationally focused payment incentives:

‘[H]aving a very concrete model that people had to follow in order to be able to get the additional funding through the tariff, was probably the most important thing [to aid implementation].

Reference 87; Doctor 1

The ethos around the universal application of the model is highly significant as it meant that the requirement to demonstrate that standards within care were met was extended throughout the city – to high performers as well as low performers – hence the increase in audit. However, the auditable standards were designed in a manner which protects (stroke specialist) professional staff:

‘[I]n order to achieve the additional uplifted tariff, they’ve got to have certain things in place... So they’ve got a protected staffing group. And that operates completely differently from every other service... And I think they know that, they can’t say to me, ‘Oh, you know, but we’ve had five staff cut from our budget,’ because if they’ve had five staff cut from their budget, I have to go back to our commissioner and say, ‘You know, they’ve cut staff, they’re not meeting their ratios,’ and they’ll have a contract conversation with the business manager of the Trust, because that’s protected through the tariff arrangement in the contract. So it’s not really – the clinical team

would be in trouble if there's no staff on the ward. It will be, it won't be the clinicians' responsibility for that service... [S]o we've protected them.'

Reference 88; Network Project Manager 3

For the Networks, PCTs and the SHA, the standards around organisational compliance to staffing establishment numbers were key. There is an assumption built into the London model that clinical staff will deliver high quality services if the economic and organisational barriers which they claim have previously held them back are removed. Standardisation (and audit) therefore was not perceived as an attack on the autonomy of professionals and consequently limiting and likely to invite resistance, rather standardisation was presented as a technique to protect specialist stroke services (from non-stroke focused hospital management). Viewed this way, standardisation and audit disciplined organisational and management behaviour rather than professional behaviour and potential resistance was countered by pecuniary incentives at the Trust management level.

These standards impact upon HASU level managers (as will be explored further in the following chapter) – promoting a firmness of approach which echoes that of the SHA senior leadership around 8 as a 'magic number' for HASUs explored earlier in this chapter. For example in the exchange below, the clinical services manager for stroke explains why an organisational standard without clinical evidence (the requirement for all patients to be assessed by a therapist within 72 hours of admission) is so important to her:

Interviewer: 'But if clinically it doesn't matter, what's going on in that hour between 71 and a half and 72 and a half makes such a difference?'

Informant: 'Well we would fail to have seen somebody in 72 hours. So it's, we would all perceive that as a failure, even though if we took a deep breath in and actually it's not making any clinical difference. I just think if you get, and I know I differ from [the consultant stroke lead at the site] on this, he's much more, 'I'm doing what's clinically relevant,' you know, ... I'm very, very keen that we do not drop the ball, and I slightly feel if we, you know, 95% isn't good enough because I think if you start accepting 95%, you'll look around and it will be 85%.'

Reference 89; Clinical Services Manager for stroke, *Kenworthy Hospital*

This perception that if standards are allowed to slip just slightly or if control is ceded at all, then there is a danger of more severe tailing off in standards recurs throughout the interview and observational data. Standards and protocols impose a uniformity across all HASU sites and impact upon supervisory staff in multiple and conflicting ways. Although the informant is aware that clinically, there is no difference between 71 and a half and 72 and a half hours, the standards impose a pressure upon her to ensure her organisation is capable of achieving a performance standard in order to validate their position as a valued HASU.

This section on standardisation and the increased prevalence and influence of audit represent the major themes which arose from the observations which were performed of the London Stroke Clinical Advisory Group (Stroke CAG). The group consisted of mainly HASU clinical

leads (mostly doctors), a senior nurse and management and network representation. A large amount of time was spent designing and discussing elements of the LMDS and the organisational and clinical standards of which it should consist. The group had the power to designate areas that ought to be measured and audited and the acceptable percentage/proportion of compliance in order to receive the respective element of the London Stroke Tariff. This then had to be agreed with a senior commissioning board. Some standards changed during the years I attended the meetings – for example, a 30 minute standard for door to needle time for thrombolysis was felt to be counter-productive clinically by numerous members of the panel and the panel successfully campaigned for it to be replaced with a 45 minute standard instead. The interactions of the group demonstrated a consistent picture of medical dominance – it was the senior consultants who spoke for the most time, with the most authority – who might occasionally disagree with and challenge each other – but were rarely challenged by any other members of the group. However, over time, it became clearer that these senior doctors were employing a ‘management’ discourse based on two key themes; ensuring that other clinicians followed the strict new protocols without exceptions; and that data was collected to provide evidence that this was being done. These doctors were acting as managers – but managers with a desire to defend the new pan-London jurisdiction of stroke care in a time of economic turbulence and politicking and highlight to commissioners that the model would be successful and sustainable.

The standards were clinically designed. Likewise the group could discuss and influence the regularity of peer review visits – there was a consensus that although implementation of the standards was progressing well towards the end of my observations – HASU managers and clinicians were desirous that the visits continued because they saw the visits as an important way of defending their (particularly nursing) staff from being sent to cover staff shortages

elsewhere in the hospital. As well as discussing the elements that would make up the standards by which they would be audited, the group spent a large deal of time discussing how to ensure that firstly the data was collected, and secondly how to counter resistance to the rigidity of the London model. With respect to the first point, there was feedback each month to the central clinical team around the burden of data collection:

‘There are audits coming out of your ears aren’t there? It feels a little bit at the moment like we’re, like we’re auditing everything that potentially could move.’

Reference 90; Senior AHP, *Kenworthy* hospital

Different units responded in different ways in terms of employing administrative or nursing staff to complete the data returns but it was clear that to the senior clinical and network leads, ongoing data collection and ensuring its continuance was essential to the role of the CAG. In most meetings, clinicians offered stories about resistance expressed by colleagues to following the rigid London model. For example, a requirement of the model is that all potential stroke patients have to go to a HASU – even if they are in-patients at hospitals without a HASU:

‘[I]f you have a hospital stroke having just had your coronary arteries done and you have a stroke, you cannot go to [the SU in that same hospital], you would have to then get into an ambulance and go to a hyper acute stroke unit that may be up in wherever. Well that’s complete and utter nonsense. And there’s no evidence to suggest that that’s what you should do.’

Reference 91; Doctor 4, Clinical Expert Panel

This type of rigidity caused much resistance and multiple discussions at the meetings, but from the clinical lead, supported by the networks, there was a commitment that perverse as it may seem, such firmness was essential in order to ensure compliance to standards. Once more this highlights the compatibility of professional and managerial goals and the shared reverence for a ‘one size fits all’ episteme and controlled approach to managing the design and implementation of the new regimes of government (Dean, 2010). Alongside this rigidity there was an ethos of collective, interventional support for providers to help them achieve the requisite implementation standards – this is described in the following section.

6.4 Section 3: Interventional commissioning

A key element of the London reconfiguration was the constructive, interventional aspect of the commissioning of the new services which was central to the push to improve and standardise care across all sites – in particular those starting from a lower base point. This was a pragmatic decision based on the poor standard of many of the submitted bids for the commissioning of HASU status:

‘We took the view, in Stroke, that actually we were not seeing something which was reflecting excellent hospitals with poor bids, that actually the poor bids often reflected [poor stroke services], not so – it’s not a judgement on the care provided by individual

clinicians, but poorly organised, poorly supported units... So we decided that the right thing to do in the first instance was to support, to decide that unit was going to be in and to provide them with support through principally the stroke networks... [We took] a commissioner interventionist approach... But actually, so, so was there a master plan that that's how we were going to deal with it? No. Was there a management theory underpinning it? No. We made pragmatic judgements in the face of how things played out, often things that were unexpected. '

Reference 92; Senior Project Manager 2, SHA

Table 8 below is taken from an NHS Implementation Options Power Point document from 2009(Appendix D reference 55) in which it is stated: 'The external evaluator panel scores showed that only one potential HASU and 3 potential Stroke Units would be able to meet all essential 'launch criteria' by October 2009' (NHS London, 2009b). This meant that the 'below the line' providers (of which there were many) would need extensive aid to get then to and above 'the line'.

Table 8: ‘Implementation Options’ (NHS London, 2009b)

| | All providers | ‘Below the line’ providers |
|-----------------------------|---|---|
| Commissioner leadership | PCTs commission, monitor and manage performance against the new specification | Formal governance and project management with clear PCT accountability |
| Planning and implementation | Plans agreed with commissioners and network | External support |
| Proper resourcing | Tariff incentivises and shares risk | |
| Peer review and support | Peer assessment to support implementation planning Network participation | Formal partnership with high quality stroke provider (potentially, direct involvement in provision) |
| Support | Network | Implementation team |

The focus at the commissioning level was not on individual clinicians’ integrity or actions – but poorly organised hospital services. Furthermore, the methods chosen to tackle these problems were designed and led by commissioners working closely with the local Networks, the pan-London Stroke CAG and the implementation team. The supportive, collaborative approach pursued by these stakeholders is highlighted below:

‘[W]e’ve worked with them [HASUs] really, really closely. And encouraged them and supported them and congratulated them, been in there with them. We’ve had all the measurement criteria, you know, the assessment, the criteria that we assess them against, but we’ve supported them in being able to reach it. So it’s not like saying, ‘Right you’ve got to do that, and we’re going to come in and see how you’ve done it.’ It’s, ‘How can we, with you, get to this standard? Alright, we won’t assess you next week as planned, because clearly you’re going to be there the week after, it’s stupid to

assess you...’ So it’s being realistic. Being realistic with people and what can we achieve.’

Reference 93; Network Director 2

Once more the approach was heavily reliant on the production of evidence of practice, or performance measured against published criteria, but the ethos around achieving this was ‘realistic’ and extremely supportive rather than punitive. It was not about judging units as substandard; rather it was about encouraging them and enabling them to achieve the requisite metrics. The seemingly paradoxical juxtaposition of *freedom* and *standardisation* is discussed below:

‘So the crucial things in the stroke standards, I think, were mostly about staffing levels, how quickly a patient needed to be seen for a particular sort of assessment, how many nurses you had to have, how many therapists, how the doctors have be organised for their rotas, those kinds of things. And people had, so people had complete freedom, for example, about how they met the requirement to always have a consultant available within whatever the time requirement was. And different people did it differently... All we cared about was that they met the standard. So, and that would, and whether people were allowed to be innovative in that way was not to do with whether they were a good unit. And we were studiously neutral on that, as long as they met the standards’

Reference 94; Stroke Project Manager 2

Within rigid standardised frameworks, clinicians were given the space to innovate freely, and ‘enact’ evidence based guidance (Mykhalovskiy, 2004; Ferlie and Fitzgerald, 2005) at the unit level in order to design and deliver care to stroke patients as they best saw fit. This also meant that local issues can be addressed locally. For example in a number of networks, consultants working at hospitals which had SU status, but not HASU status were invited to work on the HASU at a neighbouring Trust at certain points each month. This approach had the triple advantage of augmenting or maintaining the acute skills of the respective consultant, sharing knowledge across multiple sites and teams and also aiding HASU providers to ensure that consultant shifts were continuously covered. Clinicians and managers had the opportunity to design and tailor solutions to local problems – hence the seemingly disciplinary burden of increased monitoring, standardisation and measurement were presented (and felt) in productive or emancipatory terms for those working at HASU and SU level.

The increased levels of involvement of the commissioners and the links with standards and income for the Trusts were recognised as important factors in the successful implementation of the London model:

‘[The commissioners’ role has] been fairly critical as well, you know, holding the purse strings and they’ve got involved almost for the first time actually in terms of assessing the quality of the services which have been delivered to them. So they usually will come on the inspection visits, the assessment visits with the clinicians.’

Reference 95; Doctor 1, Clinical Expert Panel

Having agreed to fund stroke services with an additional £23m per year as part of the reconfiguration the commissioners, working through Health care for London and alongside the Networks and professional leadership took a constructive approach to improving care delivery in stroke care – however, this was clearly backed up by being able to withhold elements of the increased tariff if standards were not achieved. The ‘stick’ of withholding the tariff was seen by both senior SHA management and clinical leaders as an essential element of the London model:

‘And people not getting their money unless they do what they’re told [drives change]!’

Reference 96; SHA Manager 1

‘Exactly how that money [the extra £23m per year] was used was fairly early decided on that it would be linked to the tariff... And that was certainly something which I think the clinical advisory group supported from the beginning. And I think it has been the most important driver.’

Reference 97; Doctor 1, Clinical Expert Panel

These key professional and managerial stakeholders involved in the design of the systems for standardisation linked to Trust payment emphasise the importance of the ability to reward good performance and punish poor performance. However, the Network Directors involved

in the application of the policy suggested that in reality the systems which exist are not conducive to an effective withholding of payments:

‘I wrote this letter, basically saying it’s just not good enough, you know, ‘I expect to receive this information,’ you know, reminding him of the times that we’d asked for it, ‘I expect to receive this information by the end of the week. If we do not receive this information, we will be recommending to the commissioners that the tariff uplift is not paid for the period of time between,’ I think it was going to be from February through to August. So it was a significant period of time and they would have lost a significant amount of money. *To be frank, money would never have been taken away because of the, because of the way everything is. In fact it was a slightly empty threat.* [Emphasis added] But it was a threat enough to make them [submit the required information]’

Reference 98; Network Director 1

A problem therefore is the level of complexity involved in the tariff payment system which inhibits its practical effectiveness. However, the threat of withholding the tariff – even though it might be ‘empty’ – appears to be sufficient to challenge resistant behaviour by individual managers and Trusts in general. This is another aspect of exposing providers to the gaze of commissioners, networks and other Trusts – there is a peer-pressure element to the role of payments as symbolic markers of compliance and quality which emphasises a logic of *subjectification* rather than *subjection*. The stroke networks are heavily involved in this

aspect of governance. Their role will be explored in more detail in the following chapter alongside a detailed study of changes at *Kenworthy* hospital as part of the reconfiguration.

6.5 Summary

This chapter first focused on the decision-making process around where and how to locate the new London HASU services. The bid evaluation process was shown to ‘open up performance to the managerial gaze’ to a new extent across London’s proposed stroke services. However the professional and managerial consensus over quality criteria which allowed bids to be ranked ‘objectively’ was not matched by the configuration evaluation which included much more subjective criteria – highlighting the contested nature of decision making in reconfigurations (Spurgeon et al, 2010). The debate around quality and access as markers to guide the site selection was then highlighted in relation to the rigidity of the central SHA management demands that London accommodated no more than eight HASUs. The metaphor of ‘shifting goalposts’ was explored in relation to how the original criteria for choosing stroke service sites was changed by senior SHA executives in the light of unexpected results from the bid evaluation.

This led to an exploration of the relations between SHA managers, stroke project managers and senior stroke care professionals and the contrasting institutional versus pan-London outlooks expressed by each. This is interesting because it highlights elements of consensus and conflict between managerial and professional goals (Numerato et al, 2011) alongside the existence of a central SHA executive with increased managerial power, displaying ‘top-down’ NPM style leadership (Hood, 1995; Ferlie et al, 1996) whilst also demonstrating

elements of ‘reintegration’ (Dunleavy et al, 2006). Again, this points towards a complex governance regime in policy making under late New Labour (Osborne, 2006). The contested nature of ‘evidence based’ health policy making (Carr-Hill, 1995; Nutley and Davies, 2000; Goldberg, 2006; Greenhalgh and Wieringa, 2011) and the impacts this has on professionals (Freidson, 2001; Armstrong, 2002) was also highlighted here.

The next section of the chapter reviewed how within the reconfiguration the standards set and audited were jointly designed by professional leaders and network and SHA managers and signed off by commissioners linking the concerns of the LMDS and SINAP. This highlights managerial and professional compatibility (Southon, 1994; Numerato et al, 2011). The model of stroke care that was constituted was intentionally inflexible and intensely monitored. There was a strong ethos that improvement through standardisation (Timmermans and Berg, 2003) was possible and that furthermore audit could be used to protect the resources secured to improve stroke and enable stroke professionals to deliver ethically satisfying high quality care (Iedema and Rhodes, 2010). The third section of the chapter explored the concept of ‘interventional commissioning’ which demonstrated ‘reintegration’ of governance regimes (Dunleavy et al, 2006) and highlighted that alongside the increased regimes of audit, data collection and increased surveillance, there existed a space for providers to innovate and tailor care and that commissioners and central overseers provided support to improve local services (Dopson and Ferlie, 2005).

The next chapter will focus on the reformed regime of government at *Kenworthy* hospital in more detail and the influence of network governance techniques.

Chapter VII

Implementation

7.1 Introduction

Alongside an interest in change at the pan-London level, this thesis is also concerned with the effects of the reconfiguration at the micro-level – change that occurred for staff delivering stroke care to patients at the HASU and SU levels. This chapter explores how decisions and action at both levels shape and are shaped by each other. The aim here is to build on chapter V which focused on stroke care ‘problematisation’ (Foucault, 2007), and chapter VI which was concerned with the designation of the ‘solution’ to this problem at the macro-level by exploring implementation of the new regimes of government (Dean, 2010) at one hospital which was radically reformed by the London programme.

The first section will contextualise *Kenworthy* hospital, highlighting the scale of change between pre- and post-reconfiguration stroke services at the provider level and introduce institutional level conceptions of what ‘success’ and ‘viability’ in stroke services were interpreted as for those with both professional and managerial responsibility for such services, and why the hospital chose to bid for HASU status. The second section details how the jurisdictional effects of increased stroke care ‘specialisation’ at *Kenworthy* hospital impact upon the professional practices between stroke specialists and non-specialists; and also the relationships between different professional groups (medical, nursing and AHP) delivering specialist stroke care at the hospital – with a particular focus on how perceived

inadequacies in nursing care (identified in section 1) were handled. This section also discusses the ways in which stroke specialist staff at *Kenworthy* interpreted the discourse of evidence based stroke. The final section describes the role of the stroke networks in aiding implementation of the new model of care to ensure that the requisite standards were met.

Three main data sources are drawn upon in this chapter. The first is interviews carried out with staff at *Kenworthy* hospital around the decision to bid for HASU status and the ensuing changes engendered by this and provides a micro-level perspective. The second data source is interview data with stakeholders involved at senior and advisory levels across the stroke project board, clinical advisory panel, and commissioning and finance panels – focused on implementation and the role played by the clinical networks in particular. In addition to this, the chapter also draws on observation data taken from the pan-London Stroke CAG meetings, to which two key figures (professional and managerial) from *Kenworthy* were significant contributors.

7.2 Section 1: Contextualising *Kenworthy* hospital

Kenworthy hospital serves a population of over 500,000 with a Trust-wide staff of over 4,000. It was successful in its bid for HASU status in 2009. It is not a central London teaching hospital like the majority of the HASU sites, but rather based in a more suburban location and is not a neuro-specialist centre. This is of significance as it meant that the hospital had to invest very heavily and very rapidly in terms of medical and radiological resources as part of the London plan to arrive at a point at which the minimum standards

were achieved – more so than other, better established sites. Care of the Elderly Services (including Stroke services) were provided by the local community health service on the site of *Kenworthy* until the year 2000 when the acute trust took over responsibility for running the service. However, compared to the configuration of stroke care found at *Kenworthy* after 2009, the services offered to stroke patients were rather disjointed and rudimentary. As highlighted throughout the UK in the NHS London literature reviewed in the first empirical chapter, *Kenworthy* had a comparably poorly staffed, non-exclusive ‘proto-stroke unit’ with 23 beds, often blocked by non-stroke patients which meant that many stroke patients never made it to the stroke unit until many days post-stroke. In Table 9 below, data for pre- and post-reconfiguration activity and staff numbers are presented:

Table 9: ‘Pre- and post-reconfiguration data on *Kenworthy hospital*’

| <i>Kenworthy hospital</i> stroke service | Pre-reconfiguration | Post-reconfiguration |
|---|---|--|
| Beds | 23 | 50 (16 HASU, 34 SU) |
| Stroke admissions | Approx. 400 p.a. | Approx. 1300 strokes p.a. Approx. 1600 including TIAs |
| Consultants | 1 | 3 |
| Junior doctors | 1 | 8 |
| Occupational Therapists | 1.66 qualified + 2.0 assistants * | 7.65 whole time equivalent |
| Physiotherapists | 2.0 qualified + .66 assistant whole time equivalent | 8 whole time equivalent |
| Speech and Language Therapists | 1 whole time equivalent | 3.84 whole time equivalent |
| Dieticians | 0.1 whole time equivalent | 2.0 whole time equivalent |
| Psychologists | 0 | 1.5 whole time equivalent |
| Nurses | 25 | 95 |

It is clear from Table 9, that stroke activity increased substantially following the establishment of HASU status and also that a very large number of new staff were recruited (over a relatively short period). These are important factors which impacted upon service development at the hospital.

Firstly however, it is valuable to consider the historical and structural context in which services developed at *Kenworthy* in order to understand the different ways in which the various professions key to stroke care delivery ultimately came to be impacted upon in distinct ways. Compared to London's major central hospitals, *Kenworthy* hospital is relatively new, opening in the 1970s and faced more of a conflicted 'institutional identity' somewhere between a District General Hospital (DGH) and a specialist acute provider. As a management consultant involved in the stroke services bid on behalf of *Kenworthy* observed:

'[T]here was always a debate within *Kenworthy*, 'Are we a local acute hospital? Or are we a specialist hospital?' And *Kenworthy* had always had kind of pretensions by virtue of, partly the people it recruited when it was built... [It] had a lot of new ambitious doctors, it had the [Medical Research Council funded Clinical Research Centre] MRC, it had clinical research. And I know the people who were attracted there initially didn't move.'

Reference 99; Independent Management Consultant, *Kenworthy* Hospital

Although the hospital is in a suburban location and has many of the characteristics of a 'local' hospital, or a DGH, there has existed a historical strategic drive to aspire towards more than

this, and indeed towards increased specialist status. A number of informants linked this to the existence of the allied research centre. The presence of the research centre is crucial to understanding an important element of development of *Kenworthy* hospital. Although the Clinical Research Centre was closed in the 1980s, a tradition for excellence in rehabilitation and therapies had been established and impacted upon how nascent stroke services progressed over subsequent years even after the MRC had been closed down:

‘So we’ve always had more therapists than most DGHs. And speech and language therapy was also part of that. We had a lot of speech and language. I mean there were times in the, in my early days here in the sort of the nineties and the noughties, when many of my colleagues running perfectly good stroke units elsewhere, had a speech therapist for a couple of hours a week, whereas I had a full time one, it was unheard of.’

Reference 100, Doctor 3, *Kenworthy* hospital and Clinical Advisory Group

The relevance of this situation is that it encouraged the establishment of a cadre of highly qualified, well trained and ambitious Allied Health Professionals (AHPs – e.g. physiotherapists, occupational therapists, speech and language therapists) within *Kenworthy* hospital. These therapists are central to effective stroke care delivery (and normally in short supply traditionally in English stroke care) and therefore provided the *Kenworthy* stroke service with a clinical advantage over other sites in the capital, and also a high quality base in therapies from which to build on when the increased funds following the reconfiguration arrived. The high standard of AHP provision and interest in research allied with a well-

respected lead consultant with a profile within the national and London wide stroke physician community gave the trust a potential base to work from as stroke services gradually improved through the years from 2000.

Unfortunately, strong as the AHP presence and reputation was, the nursing standards at the hospital were considered weak by the informants interviewed for this thesis. The hospital suffered a serious scandal in the mid-2000s in a speciality not allied with stroke – but there is a feeling well expressed by all professional groups and managers that nursing at the hospital has been poor too often – particularly in Care of the Elderly:

‘I think that the old care of the elderly nurses will often... have been shunted into an area because nobody else will manage them properly. We don’t accept that anymore.’

Reference 101; Matron *Kenworthy* hospital

Many of the pre-existing (i.e. before the reconfiguration) nurses are described by colleagues as not very dynamic, rather uninspiring individuals who have ended up in Care of the Elderly services not through having a passion for the role, but because it is a kind of graveyard for poor nursing staff who have traditionally been unchallenged by management into performing to a higher standard. An element of the reconfigured service therefore focused on challenging these traditional institutional features, however, the legacy of these perceived strengths (therapies, medical leadership) and weaknesses (nursing); permeates these data, so that analytically, it will be useful to explore the ways in which the reconfiguration and the challenges it brings affects these distinct professional groups. It is essential to understand that

the different staff groups are starting from different perceived points of competence at the moment at which the new regimes of government are introduced and therefore the episteme and techne (Dean, 2010) of the new regime may impose different challenges upon separate staff groups.

A further key theme which percolates these data is the sense of stroke service development as a kind of ‘strategic grab’ on behalf of the hospital which links back to reference 99 and the identity of the hospital itself and the dialectic between specialism and localism:

‘[O]ur director was very supportive of the stroke project [bid for HASU status]. There was also the agenda in that there’s a lot of competition amongst the Trusts in the outer areas of London as to who is going to be the major acute centre, because again there is a tendency for smaller hospitals to downsize and for the bigger hospitals to grow... [I]t was looked upon very favourably by the management as an agent for upgrading the whole hospital to a large acute centre’

Reference 102; Doctor 3, *Kenworthy* hospital and Clinical Advisory Group

The theme of local sector-wide competition is emphasised in particular by senior professionals and the director level manager involved in the preparation and delivery of the business case forwarded to NHS London for HASU status. The director with responsibility for stroke services suggests that the Trust viewed stroke developments in existential terms:

‘[I]t was in the wind that stroke was going to be a big, you know, there was a few things that are going central aren’t they, the vascular stuff and the stroke. So we knew that for our future it is vital that we are a major acute. Otherwise we would be sucked up by *Arnott* hospital, we thought at the time, which isn’t now likely to happen. But at that time that was possible. *Wilder* hospital was moving to be a Foundation Trust and you think, ‘Hmm what’s going on there?’ So you either are going to be taken over or you’re going to survive. And the only way to survive strategically was to be an acute, a major acute. And so the stroke business case was important to the Trust’

Reference 103; Director, *Kenworthy* hospital

The historically conflicted view as to whether *Kenworthy* should see itself as a DGH or a major acute hospital in some ways was resolved thanks to the work around stroke specialist service delivery. The stroke business case made stroke care important to the trust in ways which it had not been in earlier years because it is seen as a way of establishing the organisation as more important in strategic terms to the capital than it would have been had stroke gone elsewhere. This competitive ethos between the local hospitals is remarked upon by informants – essentially a choice of being ‘*taken over or surviving*’ was fully understood by the lead clinician for stroke at the hospital who described it thus:

‘I think it was the coincidence of, the coincidence of opportunity with aspiration. So the fact that the hospital wanted to be a big acute hospital, is somebody saying, ‘If you bid right for this contract, you’re going to have 54 beds technically paid for by an outside agency which is going to bring hundreds of people in here and everybody will

say that this is a hospital where you go for strokes.’ And that will bring everything in... So they’ve actually brought vascular surgery in here, and because vascular surgery has come here, that’s going to mean that they will have to have 24/7 radiology and, you know, the whole thing has all come together.’

Reference 104; Doctor 3, *Kenworthy* hospital and Clinical Advisory Group

There was clear ‘buy in’ from the senior medical stroke team for the strategy pursued by the hospital. There is an entrepreneurial flourish to this respondent’s language ‘business through the door’ and an explicit awareness of the importance of the extra funds provided by an ‘outside agency’. This collaboration between clinical and general management leaders was important, but for the Director leading on the bid for the hospital, the key knowledge broker was an independent management consultant who brought extra skills to the process:

‘[W]e actually pulled somebody in... who is a strategic, he used to be a chief exec, so he’s one of these people that comes in and works with Trusts. He... was the one that was looking outside and saying, ‘Geographically we are absolutely bang on, we are right in the right place, they cannot, they can’t not use us because they come to us because we are easy to get to,’ and geographically when you look at the potential places, we have to be the one.’

Reference 105; Director, *Kenworthy* hospital

There is a recognition that specialist, strategic management knowledge was needed for the bid – someone who could apply understanding around how strategic case processes are interpreted at the centre as well as by the bidders, and that spending the extra money to bring this knowledge in house would be valuable in ensuring the bid had a good chance of success:

‘[M]ost Trusts are heavily operational. They’re not - they don’t tend to be very strategic because it’s all about the crisis today and next week... And what I was trying to say was, ‘Look, you know, things are not going to be as they always were. They’re going to move – special stuff is going to move to tertiary centres... So that’s a key element to your strategy which they hadn’t really been thinking about... [A]nd you get a kind of critical mass of those kind of services [e.g. stroke]. And then you become the default [hospital for other services]’.

Reference 106; Independent Management Consultant, *Kenworthy* Hospital

This subtle understanding around how competition in the NHS of the late New Labour period functioned, and the reliance on external, management consultant knowledge to give a strategic edge and presentational flourish to the application process was important. The management consultant employed by the Trust, and quoted here was an independent Public Sector specialist who had worked for many years in hospital administration and management, and at the Department of Health as a civil servant and policy advisor. His political judgement was matched by an aspirational drive from within the stroke team:

‘[I]t was very clear from Darzi’s work that he wanted these specialist centres and then little sort of polyclinics in a little part. So what we did not want to be was [unimportant]; we really wanted to become one of the players. ‘

Reference 107; Clinical Services Manager for stroke, *Kenworthy* Hospital

Driving the process was a desire to become ‘one of the players’ and the default option to colonise further specialisms on the back of the success of securing stroke specialist status. This sentiment clashes with the collaborative, network approach emphasised at the macro-level in earlier chapters (whilst chiming with the competitive edge to these relationships across different organisations). Post reconfiguration stroke services now have an explicit and quantifiable value to the management of London hospitals because they need multiple ancillary services in order to function at the requisite ‘gold’ standard designated by national and local guidelines and the funds for these services is guaranteed by the commissioners. However, whilst the changing profile of stroke has large impacts on the *external* strategy making of individual hospitals, it also impacts upon the importance of stroke and the subjectivities of those delivering stroke care *within* organisations. Stroke service delivery is now central to the successful clinical, economic and organisational functioning of *Kenworthy*. This changes a number of key dynamics within the hospital (in the stroke team and beyond). Stroke staff outlined the differences between before and after the reconfiguration in stark terms:

‘It was ridiculous [before the reconfiguration]. I mean, it was a completely undoable job, so we campaigned and we got one whole speech therapist. But now to work

somewhere where we've got four speech therapists, eight physios, seven-and-a-half OTs, psychology and dieticians – it is brilliant, really brilliant. And I do feel we have really improved stroke care – I mean, not us personally, but the London Stroke Model has really improved the way stroke services are delivered, so it's lovely to be part of that.'

Reference 108; Clinical Services Manager for stroke, *Kenworthy* Hospital

Thus stroke has a higher profile following the reconfiguration which in turn increases the power which stroke clinicians and managers potentially have to influence practice elsewhere in the hospital. The quote above demonstrates this in relation to AHP staff establishment numbers focused on rehabilitation. This section has described the context behind the micro-level study at *Kenworthy* hospital. The following section describes some of the intra- and inter-professional changes heralded by the altered regimes of government associated with the London stroke care reforms.

7.3 Section 2: The implementation of the new regimes of government at *Kenworthy*

Stroke patients now have a much better organised journey into the hospital in that they side step the procedures which apply to other patients; the ambulance teams call ahead, specially trained nurses await the blue-lighted arrival and speed the patients through A and E straight to Radiology where they get immediate scanning priorities. This change impacts on the workloads of others in different ways. For example, A and E input is greatly reduced, but

pressures on Radiology increase. The effects of some of these shifting work practices and clinical priorities are demonstrated in the following quotes which detail elements of conflict between stroke consultants and radiology consultants around how the radiology service facilitates the increased burden of stroke scanning it now faces. Rather than increase their own hours to facilitate the new stroke service plan, the radiology consultants pass the augmented work load on to their registrars – but this is problematic for the stroke specialist consultants:

‘Oh the registrars grumbled that there would be more work and that’s true, but that’s in the whole scheme of things it doesn’t have a great deal. Most of these cases would have come to them anyhow. And now at least they can, you know, if they do get home and they are called about a non-thrombolysis brain at two in the morning, they don’t have to drive in and do it. They can look at it at home. So there’s been a trade-off. They’ve got a few more cases but they don’t necessarily have to come in.’

Reference 109; Radiology Consultant, *Kenworthy* hospital

‘I think there is still resistance, for example, we have accepted that the thrombolysis rota is consultant based and all the people on the rota are basically happy with that. Radiology have still not accepted that it would be nice to have a consultant reporting the scans. So there’s all, there’s resistance from the registrars, but at the same time, the consultants have not said, ‘Okay well that’s simple; we’ll just have a consultant on call every night.’ The consultants have not been prepared to go down that road. I think we’ll get there.’

Reference 110; Doctor 3, *Kenworthy* hospital and Clinical Advisory Group

In effect the radiology department is busier as a result of having more stroke patients and greater pressure to prioritise and report on these cases within minutes in order to meet the requirement that all candidate thrombolysis patients receive treatment within the requisite time frame. The desire from the stroke consultant in reference 110 is for the radiologists to offer 24 hour consultant on call cover to do this. However, the proposed solution from the senior radiologists is technological – in that the on-call radiologist registrar can read the scan at home rather than coming in to the hospital to do so – negating the need for consultant cover. There are two points worth noting in the light of this. Firstly, with respect to the collegial nature of consultant decision making and workforce planning within the hospital – despite the confidence expressed in reference 110 that ‘we’ll get there’ the stroke consultant (notwithstanding the increased importance of stroke to the organisation) has no power to force the radiology consultants to change their practice in line with his own desire that they offer consultant on call coverage for thrombolysis decisions. The second point is that there is a change to consultant working patterns within the stroke team not replicated at a senior level elsewhere within the hospital which is linked to the explicit requirements of the London stroke care model:

‘The consultant used to do a twice weekly ward round on a stroke unit. And it was... what we used to call a ‘parachute walk around,’ so we used to parachute in and then see the patients and then scarper. Not scarper, but, you know... And that has changed. Now, for instance, on the hyper acute service, a consultant goes round every day. This

is a Sunday, okay, I'm sitting here having done a ward round, having done a TIA clinic to high risk patients and I've got to go off and do another walk as well.'

Reference 111; Doctor 5, *Kenworthy* hospital

As part of the new regime of government (Dean, 2010), there has to be a consultant led ward round every single day, so there has to be greater consultant presence – this is now monitored and made visible to the RCP, networks and commissioners by real time electronic audit for every single patient. The reconfiguration has aligned the goals between the stroke clinicians and Trust management linked to the prioritisation of stroke care in the light of the London Minimum Standards and is seen by both management and medical communities as a *productive* change:

'[O]nce he [Doctor 3] knew that the management were behind him, he was prepared to get on board and go the extra mile. So instead of being somebody who was kind of very difficult in all these big political meetings and saying, 'My service is crap, and it's all your fault because you won't give me any money,' he actually was then prepared to come in at weekends'

Reference 112; Director, *Kenworthy* hospital

Both the goals and means of the senior stroke physicians and Trust management coalesce through the protocols, targets and tariff rewards of the new London model. As these physicians come to specialise ever more closely and exclusively in stroke and stroke alone,

these consultants talk about how the new stroke rules work in their favour and inspire furtherance of dedication – they see these technical developments in *productive* rather than *disciplinary* terms – despite the fact that in many ways their working practice may be viewed as more restricted and certainly more closely scrutinised. However, whilst the consultants recognise that the prioritisation of stroke care may cause resentment amongst their non-stroke specialist colleagues, it is the therapy team managers who voice these feelings of unease most eloquently:

‘[Y]ou can see the other teams where they have no money and no staff; they look at it like, ‘Oh... [you have everything you need] up there, so stop gloating about it.’ And then you can see the difference in attitude. I mean we have a very good team, so we can joke about it, you know, in stroke you’ll have everything what they don’t have. So I think you’ll find that the dissatisfaction is quite apparent.’

Reference 113; Occupational Therapy Lead, *Kenworthy* hospital

There is expressed resentment about the increased power and influence of stroke services within the hospital from other groups – most frequently articulated by therapies managers who have to designate staff to both stroke specialist and non-stroke areas of the hospital and express unease about consistently prioritising stroke at the expense of other services – for example another AHP manager felt uneasy about the potential knock-on effects that stroke specialisation might have for other non-stroke patients in the hospital. Significantly, in contrast to the AHP leaders’ experiences, the specialist stroke medical consultants do not face such conflicted remits – they bat for stroke and stroke alone – they have more staff to aid

them in this goal and no real need to consider care beyond the speciality of stroke. These two themes; namely stroke staff increases and different levels of integrated specialisation within and across different professional groups now discussed with a particular focus on nursing, as it is in nursing that the staff numbers increase most significantly, and also within nursing that the traditional institutional handicaps at *Kenworthy* hospital noted in section 7.2 are most prevalent.

One of the key problems with stroke care diagnosed in the NHS London work was that it was understaffed across all professional groups. Therefore much of the increased finance for stroke in London was focused on increasing staff numbers: managerial, medical, nursing and AHP. A second important issue was to increase the specialisation of the staff tasked with caring for stroke patients. As detailed in the LMDS documents, the staff increases were connected to negotiated standards related to different elements of care which impacted differently on the respective various professional groups. A recurrent theme in the interviews with senior stroke team members at *Kenworthy* related to the difficulties faced in trying to integrate such a large number of new nurses into the unit and inculcate a *stroke specialist ethos* following the reconfigured model of care in such a short period of time. There are two particular issues here; firstly the lack of suitable candidates available to fill the posts; and secondly, the historic challenges the hospital has faced around nursing culture.

The speed of the expansion of stroke care at *Kenworthy* caused problems in particular around nursing recruitment which leads to problematic issues related to recruitment per se and high quality recruitment in particular. This requires increased management oversight:

‘[W]e’ve got 98 [nursing] staff on the stroke unit; we were all brought together in a flash, which has brought with it lots of challenges... we just over kind of accelerated the recruitment process because we had to get people into jobs and we are now paying the price for that. But [although] it... paints a pretty grim picture; it's not that bad. It's a small proportion of the staff; however, it's significant enough for me to have to make a change.’

Reference 114; Matron, *Kenworthy* hospital

Given the short turnaround time between winning the contract to provide HASU care and opening the unit, and the fact that within London, the number of stroke nursing opportunities increased rapidly due to the reconfiguration making recruitment particularly competitive for hospitals, it is unsurprising that the hospital struggled to fill the posts. In response to this, the hospital recruited a large number of nursing staff from abroad. In order to standardise the care offered by the rapidly expanded nursing team, the hospital commissioned a special competency programme based on the London nursing standards from a local university and all the nurses are required to undertake the course:

‘I’ve been very clear with [the] University is that we need something... that is kind of old fashioned in its approach; it's not a touchy feely academic course, all about reflection and that kind of stuff. It is actually about hard facts, giving them some work to do, giving them the hard facts, testing their understanding of that and then, through a series of ward based competency assessments, assessing how those staff have been

able to turn all that information... And it will happen, I'm hoping, for most of them, for some of them it won't... [A]s long as they are still good, caring, compassionate nurses, I might put them somewhere else. They might be better suited on this rehab part of the unit rather than on the fast action part of the unit. So we will find something to meet their skill set unless they're a disaster zone.'

Reference 115; Matron, *Kenworthy* hospital

There is a notable disdainful tone in much of the discussion around the competencies and abilities of nurses at *Kenworthy* from senior figures which is not replicated with reference to other professional groups – exemplified by the use of the term 'disaster zone' for example above – and a desire to get back to nursing basics – 'not touchy feely stuff' – based on 'hard facts' and 'testing' and increased discipline. This type of language is also used by other respondents and perpetuates a narrative in which nursing is seen as failing which links back to the historical narrative of the poor nursing culture at the hospital:

'The nursing has got a lot better, but they're still our weakest link and we have, I mean it's really difficult to know what to do about that... Again I think there's a difference between the professions. The therapists are very self-motivated. They will ask questions, they will go and look up answers, they will set up teaching groups for themselves, they will make themselves aware of what's going on. The nurses don't seem to do that. Again I may be being very nasty to the nurses, it may well be that they spend so much time wiping bottoms and cleaning up vomit and that sort of thing

that actually they don't have the energy and that is fine, because when push comes to shove nobody else does that work and that's their ultimate goal.'

Reference 116; Doctor 3, *Kenworthy* hospital and Clinical Advisory Group

There is a disciplinary element to the discourse used to characterise the stroke nurses work at *Kenworthy* which occasionally veers towards the disdainful. The nurses seem to suffer from rather disparaging attitudes from senior nursing managers and senior medical colleagues. In comparison to the doctors and the AHPs, there is a sense that the nursing staff are lacking of the agency and motivation to achieve the requisite competencies. Whilst the doctors and the therapists appear capable and willing of transforming their roles and practice to become more skilful and evidence based (increasing their professional status within the hospital in the meantime), there is a sentiment expressed here that the nursing staff are unwilling to push themselves further than the minimum to learn new skills, and indeed cannot be trusted to improve themselves in order to meet the required standards (so need to be disciplined into so doing).

At *Kenworthy* the changes in regimes of government introduced by the reconfiguration programme impacted upon different professional groups in different ways. The medical consultants now delivering specialist stroke care have responded to their new circumstances by actively extending their specialist status – expressing dissatisfaction with other (non-stroke) consultants – for example the radiologists for not increasing their respective responsiveness to the needs of stroke patients. They express pride in increased *presenteeism* and the benefits that daily consultant led ward rounds will have for their patients. In contrast,

the narrative around the development of nursing may be characterised in less successful terms: the historically low quality geriatrics nursing pool was rapidly expanded reflecting the needs of the timeframe of the reconfiguration leading to the recruitment of nurses who fail to share the ethos expressed elsewhere (i.e. amongst other professional groups) around evidence based stroke care and proactive professional development. To work within the parameters of the new regime of stroke care, the nurses need interventional remedies (competency training and close monitoring). The position of the AHPs falls somewhere between those of the medics and the nurses – on one hand they have the resources and staff numbers they previously could only dream about, and the opportunity to foster new specialist roles within stroke care, but on the other hand, they are under new increased levels of surveillance which place increased pressure on their professional group and at the same time, their managers come under pressure with relation to prioritising stroke above all other areas with potentially detrimental effects for non-stroke patients for whom they still have a professional responsibility.

It is important to emphasise that increased regimes of measurement and management do not just impact upon the nursing staff – all staff face a radically augmented regime of accountability following the reconfiguration than they did prior to it. An increased management presence is represented by an amplification of protocols which cuts across professional lines:

‘[Y]ou've got to have a standard that we work to and we measure people against.... you know, when you're setting up a unit like this... [you introduce a] standard operational policy and then protocolise [it]’

Reference 117; Matron, *Kenworthy* hospital

‘I mean it’s just made the nurses aware of the fact that we simply are not prepared to accept any excuses, this has to happen. With the thrombolysis and the targets around thrombolysis, we have a review meeting every month. The nurse and the doctor who saw the patient are named. And if we don’t thrombolysed them within 45 minutes, we want to know why, ‘Give us your reasons.’’

Reference 118; Doctor 3, *Kenworthy* hospital and Clinical Advisory Group

As the accepted processes for all staff are re-written into local protocols which reflect the LMDS and then SINAP requirements it permits benchmarking of actual performance against ideal, agreed standards. This is important as it makes individual and team actions visible both within the HASU at *Kenworthy* and outside the hospital via ongoing audit. Standards are more explicit and failure is made more public – professionals have to be able to account for their actions in new forums within a strict framework in which senior clinical figures ‘*simply are not prepared to accept any excuses.*’ Alongside this, managerial accountability increases as new tiers of stroke specific management are introduced – most obviously in the shape of the new clinical services manager for stroke – a role which previously did not exist prior to the reconfiguration.

The Clinical Services Manager operationally manages the stroke service as a distinct service and ensures that the performance targets are met, which in turn shields the Director and lead consultant from such a role. Secondly, she also plays an important discursive role supporting

staff working in the stroke service who may be managed externally (her background as a therapist is potentially important here). There are also new levels of nursing management introduced as the ward expands; the new matron (with responsibility for care of the elderly services, who supervises three senior nurse ward managers). There is a research nurse post established and the nurse led role of HASU coordinator with responsibility for repatriation issues and data returns.

Of all the changes, perhaps the most significant is the augmented control and surveillance introduced by the increase in clinical performance measurement against LMDS and SINAP standards:

‘I mean it’s an absolute nightmare, I have to say and I’m constantly having to spend money and extra money on people to input and feed the beast, which is just, well horrendous.’

Reference 119; Director, *Kenworthy* hospital

Despite the external costs and frequent lamentations around the increased audit, there is an expression from professionals within the hospital that unlike other government imposed targets (the 4 hour A and E wait being the classic example offered), these targets are clinically relevant. Furthermore, because they are clinically relevant and appear to focus on clinical outcomes (as opposed to ‘political’ process measures), they strike a chord with a governance narrative for clinicians and do not face serious resistance. However, one of the

stroke consultants suggested that the burden is increasing beyond clinically focused data towards process data which adds burden to his workload and is not the best use of his time:

‘[W]hat happens is we write down the time that person entered hospital from the A and E records, the time that person was first seen by a member of the stroke team, the time the person actually arrived on the ward. So this is we’re having to put down, as clinicians, on the ward round, as opposed to say someone from admin being able to do it.’

Reference 120; Doctor 5, *Kenworthy* hospital

There is a sentiment here that elements of the increased audit regime stray into bureaucratic overload and a focus on process recording. This highlights a distinction between ‘productive’ and ‘counter-productive’ elements of increased audit – where audit enables clinicians to meet previously troublesome (and clinically important) benchmarks then it is looked upon in favourable (productive) terms, but where it just the increased demands of audit fail to do this, it is seen in less favourable (disciplinary, or counter-productive) terms. However the productive power of increased audit for certain groups within a profession may in turn have disciplinary effects on other (less senior) colleagues. For example, one of the more junior doctors suggested that he and his colleagues felt under pressure from the ‘bosses’ (consultants) to meet targets as these data items reflected back on the consultants and led to comparison and competition with other clinicians at neighbouring sites:

‘I think there is probably a kudos to getting things done as quickly as possible. And I know that the consultants have quite a healthy competition with other stroke units and they’re constantly comparing numbers and data with say, for example, *Burridge* hospital or *Deane* hospital and they’re quite pleased that they’re doing more and they’re doing them [treating patients] quicker and so on and so forth... I think they are motivated by targets in terms of, you know, driven by the fact that certain percentages have to be seen and thrombolysed within half an hour, 45 minutes.’

Reference 121; Doctor 6, *Kenworthy* hospital

There is an element of professional pride for the consultants in being seen to meet their targets and potentially ‘beat’ rivals - the increased visibility both inside and outside of the hospital acts as a productive force for ambitious consultants. This in turn leads to pressure for the juniors not to make errors and demonstrates increased consultant control across the thrombolysis process in this example. When asked about the ramifications of failure to meet a target this junior responded thus:

‘[T]here’s frustration. I mean lots of temper loss and – nothing quite too bad. But there’s obviously frustration that things haven’t moved forward unless there is a good enough reason.’

Reference 122; Doctor 6, *Kenworthy* hospital

The pressure to perform, and lack of a place to hide if and when targets are missed or assessments are failed arose as a strong theme amongst the informants – especially for this manager with exclusive managerial responsibility for the target delivery:

‘I would die of shame. I mean I don’t want to overstate that, I would actually, I think, die of shame if we failed an assessment. I really, I would take it very personally, you know, and I really do feel, I couldn’t bear it, couldn’t bear it if we missed.’

Reference 123; Clinical Services Manager for stroke, *Kenworthy* Hospital

Reference 123 offers an indication of the extent to which the surveillance process has permeated the subjectivity of this manager. She has ultimate responsibility for ensuring that the overall targets (medical, nursing and AHP) are adhered to and when I interviewed her for the second time above, she had just completed a highly stressful peer review audited visit led by network and SHA officials. She appears to have internalised the pressure manifested by the new audit regime. A significant insight around how such pressure may seep downwards within the organisation due to pressure and stress is highlighted in reference 124, along with an explanation around why despite the negative elements of surveillance she remains convinced of the necessity of the new regime:

‘[T]here was a lot, it was very difficult at the beginning because the therapists were all crying in the corridors and saying, you know, they felt really, they felt like they were being watched and they were being monitored and, you know, everything they did was... well, yes. Welcome to 2010 – you are being monitored, you are, you know,

and... my love, if you think you're monitored and under pressure, spend an hour with me, you know. It is, but I mean, I think I've really, I really believe it's the right thing, because, you know, those standards and the evidence is there and if we were not being... you know, if we haven't got... We ought to be delivering the service to golden standards because it's the right thing to do, but actually, you know, if we weren't being monitored and weren't being watched quite so closely, and it is micro management, you know, then I think things would slide and slip. I mean, they just, they just would, you know, so...'

Reference 124; Clinical Services Manager for stroke, *Kenworthy* Hospital

Despite the pressure it causes her (reference 123), the same informant in reference 124 suggests that this inherently discomfiting force is simultaneously of productive value for her as a manager because without it 'things would slide and slip'. Audit here functions then as a disciplinary power, and whilst she clearly dislikes some elements of it and the pressure which it submits her to, at the same time she is very willing to use the same pressure on subordinates in order to achieve the mandated goals of the new regime of government. Her senior nursing colleague agreed that despite being critical of elements of the 'bloated' audit regime, it is necessary because it 'pushes' them to improve care. So the disciplinary, pressurised nature of increased surveillance can be channelled in productive ways by managers in order to improve practice. This is particularly so with respect to nursing at *Kenworthy*. These data consistently show how respondents highlight the ways in which the external audit demands allow them to monitor the competence of the nursing staff locally. There has been a cultural shift focused on increasing the detail of documentation that the nurses make for each patient:

‘When we first came, [the documentation would state] ‘I went to see a patient, assess patient. They need to be thrombolysed.’ That was about all you got, two lines across the notes. Now it’s, ‘I went to see the patient, did an HSS, I did an assessment, did a CT scan, decided in discussion with the consultant, the decision was this, the decision was that, transferred to the unit.’ And you’ve actually now got a history of what was actually done, which was much, much better.’

Reference 125; Ward manager 2 (and nurse), *Kenworthy* hospital

There is a strong sense expressed by both senior nursing and medical figures that a key tool allied with external audit lies around making the nurses responsible, accountable and identifiable for their actions and potential failings. This in turn appears to be internalised by the nurses and their managers:

‘I have to make sure that I work together with the managers to make sure wherever we are failing as nurses, it has to come out.’

Reference 126; HASU coordinator (and nurse), *Kenworthy* hospital

Clearly then, an important element in challenging the cited historic weaknesses in nursing care at *Kenworthy* has been the increasingly stringent audit regime – making practice – both successful and unsuccessful – more visible to all and open to increased control. However, the

position and experience of AHPs is different. Many therapists expressed a sense of dislocation around the metrics used to measure their performance:

‘How many of these patients, on which days are the patients appropriate for 45 minutes [of therapy]? So if the patient is unconscious or is unwell because if they have infection the patient isn’t appropriate, right. So a patient’s there [on the SU] for a month and for ten days he was unwell or five days he was unwell, we didn’t give that therapy because he was medically so unwell or for whatever reason... So, in fact, occupational therapists, we worked very hard, it was extremely stressful, but there are problems with this when this 45 minutes end, their expectations. Some of them are, you know, we felt that it was a bit too much, because in fact according to our calculations we did 90% but on the Sentinel, it came out at 57 or 53, I forget, it was a huge disappointment that was, but you know that you’ve done the right thing.’

Reference 127; Occupational Therapy Lead, *Kenworthy* hospital

Formal audit, as part of the new regime of stroke care focuses more heavily on medical and nursing interventions than it does on therapists’ work. However, the two main criteria which are focused upon in audit terms (45 minutes of rehabilitation per day, and recording of an AHP assessment within the first 72 hours) are both problematic for AHPs. Firstly, it was suggested that there was no strong evidence base to specifically demonstrate that 45 minutes daily rehabilitation is beneficial. And secondly, the 72 hour therapies assessment target leaves little discretion for the AHPs in interpreting it and allowing for patient co-morbidities for

example. Nevertheless, the AHPs at *Kenworthy* expressed a commitment to increasing their commitment to evidence based working.

Perceptions of what evidence based practice is and what an evidence based practitioner might be are simultaneously shaped by the wider (educational and professional) discourse in which practitioners are exposed to dominant trends and disciplined into becoming certain professional types (Lambert, 2006). In turn, this exposure via dominant educational paradigms may lead to promulgation of the discourse to subordinates, or juniors:

‘Basically since I started my MSc it’s kind of opened up my mind that how much we do not use evidence in therapy. And we read about it all the time, you know, we attend journal clubs and things, but no one actually ever thinks of how to practically apply it in the setting. And that is one of the things that I actually kind of learned from my research, being at university, is how we should be applying this knowledge that we are getting... And so I’ve been trying to promote evidence based practice since – I think it’s kind of, and so being in a senior position kind of allows me to kind of do a lot of training with the junior therapists.’

Reference 128; Occupational Therapist, *Kenworthy* hospital

The evidence based episteme appears to be dominant in education strategies applied to modern health care training – this transcends just medicine and includes therapies and nursing. Exposure to this episteme during training and promotion of them to the next generation is linked to how health care professionals on the HASU discursively develop their

subjectivities as stroke specialists. Respondents describe an educative framework in which they (as seniors) inculcate juniors within the dominant Discourse. The respondent above has the agency to make such decisions as to whether or not to promote evidence based care – she is free to decide how to direct her practice - but she sees part of her role as a senior as being a proponent of evidence based care. There is also a coercive element to this discourse, but coercion is justified because evidence based actions, standards and guidelines are there to protect patients – highlighted by the following quotes:

‘It’s, first and foremost I think it’s the patient care and safety. And also they are standards that are set within the stroke network which have to be met. So according to these standards we are also actually being assessed according to the evidence that has been given that – so if you don’t meet, if you don’t practice evidence based treatments, you’re bound to fail on your standards, so it brings down the whole, the Trust as a whole. So I think those are the motivations’.

Reference 129; HASU coordinator (and nurse), *Kenworthy* hospital

‘So you don’t want it to be ruined by people just coming in and doing what they like’.

Reference 130; Ward manager 1 (and nurse), *Kenworthy* hospital

Open dissension towards guidelines and surveillance is difficult if such managerial tools are explicitly understood as protecting patients – resistance, or counter-conducts (Foucault, 2007) then becomes ethically questionable. Furthermore, the network link with guidelines adds

local and regional credibility to the new regimes of government and practice, and finally, the implicit idea that failure will ‘bring down the Trust’ in some way, adds a further pressure to conform.

Professionals at *Kenworthy* express a desire for discipline (from themselves and colleagues) in order to meet imposed goals as highlighted below. The digitally delivered and data heavy requirements of audit lead to a performative disciplinary framework (Spicer et al, 2009) centred on professional reflexive action:

‘It’s our professionalism and we also need to feed back to the Department of Health the things we’re actually doing. So we’re actually achieving governance within our own unit. We’re actually monitoring ourselves, we’re actually achieving targets, and we’re quite open if we’re not achieving, and what we actually do to change. You can have eight very good weeks or something and then very bad week. So what happened in that bad week? How do we tackle that week? How we are doing and prove what we’re doing and it’s about developing ourselves.’

Reference 131; Ward manager 2 (and nurse), *Kenworthy* hospital

The increased audit regime heralded by the reconfiguration (where previously there was ‘*a sea of vagueness*’ around stroke care performance) points towards a colonising effect (Power 1999) whereby the practices and goals of the audit regime are internalised by (some) staff. In reference 131 above, part of the desire to follow guidelines and feed them back to the centre is emoted as a manifestation of ‘our professionalism.’ This indicates a form of reflexive,

disciplined professionalism aligned to a specific shared episteme of modern stroke care. Frequently the ethical attachment to the importance of evidence based practice is deep and seemingly heartfelt, as presented below:

‘[W]hen I’m using something that is evidence based, I’m confident and proud of myself that whatever I’m giving for my patient at that point in time, as long as I know that’s the right thing to do for my patient and that I’m giving them the better care possible.’

Reference 132; Stroke research nurse, *Kenworthy* hospital

This ethical commitment to the values of evidence based care demonstrated by most respondents at *Kenworthy* may be used by general and professional managers to ensure that standards are adhered to – thus making such ‘ethical subjects’ either more susceptible to managerial coercion, or less dependent upon the need for it. This is not to say that through these data respondents do not reflect on the nature of the evidence behind guidelines critically (*‘guidelines not tramlines’* - is a term used by one senior consultant to demonstrate his appreciation of this) and the difference between politically and clinically motivated targets, more critical voices tend to emanate from more senior figures – it is those lower down the hierarchy who may come under greater stress from the increased and visible performative nature of the new stroke care regime. The pressure to perform, *and to be seen to perform* is high in the new stroke service. Transparency of data aligned with personal pride disciplines performance at the apex of the stroke service in the hospital and the pressure is felt lower

down – for example a senior nurse leader talks of the need for juniors to ‘*buck up or get out*’ and a SLT suggests that failing to meet the guidelines is not an option:

‘I think it’s because it’s from high up, you know, we’ve got a very high supportive like management high up. But then saying that, because we have such high – the management have such high visions; it can cause stress lower down.’

Reference 133; Dietician, *Kenworthy* hospital

There is a ‘hard’ management style discernable at the *Kenworthy* stroke service, committed to achieving the agreed standards and staff are not free to fail to meet the guidelines – the regimes of government heralded by the reconfiguration emphasise increased performativity and calculability for doctors, nurses, AHPs and stroke service managers. So the values of evidence based stroke care are embedded in the staff working in the *Kenworthy* stroke unit. Evidence based health care as manifested as the new stroke episteme is represented as a disciplinary force with both productive and repressive power, yet resistance to the new regime is seemingly low despite the pressure on staff to perform being clearly greater than prior to the reconfiguration. This challenges concepts of clinical autonomy:

‘I think people will talk to you about, you know, are you allowed to have autonomy to do things badly? And that’s ultimately the bottom line, is do you allow people to give suboptimal treatment? And I think what we’ve established is, no you’re not allowed to give suboptimal treatment.’

Reference 134; Doctor 1, Clinical Expert Panel

This is an interesting quote because it presents the view of one of the senior clinical decision makers of the London programme for reform highlighting the problems with traditional conceptions of clinical autonomy. Essentially, if autonomy means freedom to deviate from the agreed episteme of stroke care delivery – then such autonomy following the reconfiguration has become unacceptable. The concept of autonomy here is shown to be rather subjective and linked to professional value judgements explicitly emphasising the importance of patient care whilst implicitly highlighting the new control of senior professionals over their colleagues. It is important to reflect on the fact that prior to these changes, the staff had little power or autonomy to achieve gains for their patients due to structural and organisational barriers. Indeed:

‘I won’t say that I’ve lost that autonomy because I’ve never ever had that time. You see. I was one and a half for 23 patients.’

Reference 135; Occupational Therapy Lead, *Kenworthy* hospital

‘I really can’t make any excuses now because the resources are... there now.’

Reference 136; Ward manager 1 (and nurse), *Kenworthy* hospital

Autonomy is a relative concept dependent upon structural and institutional factors impacting on the situated agency of actors. It is linked to ethical, professional values around local

discourses of patient safety and best care. How (and by whom) EBHC is defined in relation to the question of autonomy is significant – these data suggest that it is a complex and contradictory relationship which can shift dynamically amongst different professional and managerial groups – but that traditional control versus resistance (Numerato et al, 2011) narratives are very much open to question. The changes at *Kenworthy* as a result of the reconfiguration can only be understood in the context of what went before. These changes are multi-factoral and highly complex, but it is apparent that both clinical and managerial staff do appear to face new challenges to those they previously encountered; which has impacted on their subjectivities in sometimes contradictory ways.

Having focused closely on change at *Kenworthy* so far in this chapter, the final section reviews the role of the stroke networks in the implementation and functioning of the reconfigured stroke service in London.

7.4 Section 3: Network governance

The National Stroke Strategy of 2007 (DH, 2007) recommended the extension of the existing local cardiac networks into stroke care. In London there were five sector specific stroke networks responsible for distinct geographical areas. The aim of the networks was to improve and standardise care across all providers within each network through local collaboration and sharing of best practice. The literature produced as part of the reconfiguration process emphasised their ‘neutrality’ as an ‘unbiased’ link between commissioners, clinicians, managers and patients (NHS London, 2008a; 2008b); focused on increasing the speed of improvement of care for patients. They were dedicated to the ‘*development of strategy*,

clinical and service user engagement, pathway development, brokering and facilitation, transforming evidence into practice, driving improvement through benchmarking and performance monitoring and developing service specifications' (NHS London, 2008a). The three network Directors interviewed were full time managers with backgrounds in health care as therapists/nurses, other network staff interviewed had non-clinical backgrounds. The roles of the networks expanded in the roll out of the new regime of practice and included close monitoring of the performances of their local trusts against LMDS and SINAP criteria.

Numerous informants emphasised the importance of the five sector specific Stroke Networks in the implementation of the London model of reconfigured stroke services. The networks were funded by the Department of Health and local commissioners and held no institutional alliance to any providers and thus had an independent status which was useful in terms of legitimacy, but also they held no line management responsibilities over provider staff which meant that their influence had to come through collaboration, discursive influence and negotiation:

'If somebody asks me what my job is, external to the health service, I say I do arbitration, facilitation and negotiation. Not necessarily in that particular order. But I would say, rather than a buffer, we are actually the conduit, we bring everybody together. So we provide the commissioning viewpoint and expertise to the clinicians and we provide the clinical expertise to inform commissioning. And I think that's critical. We're the ones who put them all in the same room.'

Reference 136; Network Director 2

There is an assumption that commissioners and providers have inadequate knowledge of the roles played by each other and that therefore the networks were established to mitigate against these disparities in knowledge (Rhodes, 1997). This also functions at a Trust to Trust level as peer reviews are carried out by clinicians from neighbouring hospitals which elucidates best practice and common problems. However, from senior managers suspicion was expressed around what a 'network' is and does:

'I think the worst side of networks, which is, 'Oh let's all get into a nice cosy group where we all do things together and we'll call ourselves a network because then we might get away with the fact that we can't stand each other's guts, because we never have been able to and now we can't still.' That's not what that was about, because this was quite a focused piece of work, that where they went into the units before they were allowed to go live, before they got their money, was not, was not, was hard edged. So I think the strength of it comes through, through – the words I would use is, aren't 'networks,' but it's about peer support and peer review rather than the different connotations with the word 'networks'... That clinical leadership, peer review and peer support is the thing that's driven the standards and I think that's tremendously powerful because we always compare ourselves first with our peers. And that's the thing. And that the networks provided some facility and supportive infrastructure to enable that to happen.'

Reference 137; SHA Manager 2

This quote is worthy of detailed analysis for a number reasons. Firstly the description of a ‘nice, cosy group’ hints at a disdain for the discursive non-hierarchical nature of this form of governance within the NHS which departs significantly from the command and control form of management espoused by this and other senior SHA managers elsewhere within the interview data. There is an indication that this manager views a certain traditional concept of network governance in rather negative terms and furthermore disingenuous as it is an attempt to conceal the fact that ‘we can’t stand each other’s guts’. This suggestion points to deep seated and long-term competition between local NHS organisations and mistrust which marginalises the ability to collaborate. The role of the networks emerged in a majority of interviews carried out for the thesis - usually focused on the implementation phase of the reconfigured stroke service model – but this manager is the only informant to offer such a critical standpoint about the ‘softness’ of networks as a governance technique and also to emphasise the traditional enmity between some NHS providers. Finally it is notable that she suggests it was the ‘hard edged nature’ of the stroke reforms that enabled the networks to escape such a negative fate and ensured that a competitive, comparative element of peer review was built into the constitution of the stroke network’s remit. This does not correlate with the views of other respondents – in particular those running the networks. The network Directors themselves downplayed the ‘hard edged nature’ of their roles and emphasised the ways they used ‘soft skills’ to influence high profile hospital Chief Executives over whom they possessed no authority:

‘And my message to *Stancliffe hospital*’s CEO was, ‘This is going to be really embarrassing for *Stancliffe hospital* if you’re the only HASU that isn’t able to open on the dates that it was agreed that you would be open.’ And he said to me, ‘So we are the only HASU, are we? I’d heard,’ he said, ‘I’d heard a rumour that *Wilder hospital*

were struggling as well.’ And I said, ‘Yes you’re right, they are struggling but they are opening beds and you will be the only [one not to open].’ And he said, ‘Well you need to come and see me on Monday.’ I went to see him on Monday; we talked it through, the HASU beds were opened 1st February. And, you know, but it’s interesting isn’t it, that as an organisation, I have no statutory authority over anybody. And yet I can phone up any of the chief execs within my patches. And I get into see them within a week, which I think is quite interesting, and that shows the influence, I think, the networks have.’

Reference 138; Network Director 1

This network director expresses slight incredulity at the extent of her influence over hierarchically powerful teaching hospital CEOs. This reference is particularly revealing as it demonstrates how there is a competitive element built into the nominally collaborative ethos of network working – opening up performance across networks of affiliated trusts again increases transparency and accountability. Alongside this there is also the potentially shaming element of being recognised as performing below the accepted grade of your peers for the corporate outlook of the trust.

At the HASU level, the networks facilitated practical staff development initiatives which fostered collective learning:

‘We also then had closer working relationships with the other HASUs which was never there before; every hospital was sort of independent. But we now meet monthly

with the other HASUs and we've actually put together a competency pack for all the staff to be developed on.'

Reference 139; Ward manager 2 (and nurse), *Kenworthy* hospital

Again this facilitates the standardisation agenda at the heart of the London model and demonstrates the practical benefits of network governance to staff tasked with implementing the reforms. For staff such as the ward manager above, the influence of the networks is essentially positive in enabling him to collaborate with peers from other sites and increase staff competences. His manager, in the following quotes explains how she uses the rhetorical power of the network to push her own agenda:

Informant: 'I mean what's been, what's been really helpful for me is the, I can kind of use the network like the bogey man, and I certainly do that with, more with seniors to me than juniors. So I will...

Interviewer: So in terms of defending your staff ratio...

Informant: Oh absolutely.

Interviewer: That kind of thing.

Informant: You know, 'I'd love to help you, love to give up some nurses, I just can't get it past the network.' And I'm quite shameless about that.'

Reference 140; Clinical Services Manager for stroke, *Kenworthy Hospital*

In keeping with the increased audit regimes, an important focus for the organisational pressure which the Networks bring to bear is centred on Trust management by constraining the abilities of non-stroke specialist managers to remove stroke specific manpower resources. In this sense the pressure is not aimed at the clinical staff based on the HASU. The power of surveillance added to 'soft' negotiating skills (and the rhetorical threat of tariff payments being withheld) is employed to pressurise senior managers to dedicate sufficient resources to stroke care. In this way the Networks are mobilised and perceived as supportive partners by patient facing staff, and enable local stroke specific managers to portray them as 'bogey men' to senior general managers. The surveillance they offer is thus interpreted as a productive force. This is now explored in more depth.

A striking element of the ethos of *improvement through standardisation* in these data is the seemingly paradoxical sense of increased freedom for clinical practice emerging via increased control of organisational systems. At the centre of the stroke reforms existed a powerful SHA executive team with direct line management over very senior staff (i.e. CEOs, Clinical Directors, Financial Directors) at all London PCTs and all (non-FT) NHS hospitals, and good links with the senior teams at the London FTs. This affords the executive team great influence over the priorities and goal set for the senior managers in the city:

‘So your objectives for the year, every chief executive in London and every director here, I want to see where your contribution to taking these things forward figures in the top three things on your priorities. So don’t tell me that because you’re, I don’t know, working field ABC, you don’t therefore have to have a, you know, so just because you’re a finance director doesn’t mean that you, this should be at the top of your list. How are you, as a finance director, developing the stroke tariff in London? It should be at the top of your list just like you’re the chief nurse. What are you doing about the recruitment of specialist stroke nurses in London? You know, if you’re the director of operations, what are you doing about making sure that there’s an operating environment that will support these changes?’ So those were the – I insisted on those being at the top of everybody’s objectives. And therefore, when their appraisal was done, if they hadn’t done it, then they wouldn’t get a good grading.’

Reference 141; SHA Manager 1

So this senior SHA manager has great power to shape the context (Grint, 2005) in which stroke care is prioritised by senior hospital and commissioning management across the city. This may be achieved by the threat of punitive action – poor appraisal means a poor grading which in turn means a loss of bonus and/or reduced prospects for further promotion. This is not the ‘cosy chats’ of the Networks amongst local clinicians and managers – rather it is strong, clear ‘top down’ management of senior managers in order to brush away organisational barriers to implementation. Being senior within the SHA, she can set the strategic goals for the city and rely on the Clinical Director (for stroke) to manage the clinical or professional elements of change. The fact that the (now) Clinical Director for stroke in the city had his own service down-graded is turned to strategic advantage:

Informant: 'I think weirdly, I mean in the early days of the stroke project, [the Clinical Director for the city] was very pro maintaining it at *Burridge hospital*, very pro, and understandably, it was his unit, it was the highest performing unit in London, why would you want to shut it, you know. He was very sceptical about the access, very sceptical about *Arnott hospital*. So when he was appointed to the job, before we confirmed the job, I saw him and said, 'If you're going to do this job, you've got to not, you've got to forget about keeping *Burridge hospital* [HASU open],' and he'd come round to the view that the right thing to do was take forward the eight.

Interviewer: *And in terms of the credibility then?*

Informant: Then it's fantastic, because then if anyone wants to say, 'Well I don't like this because I'm losing my singlehanded neurologist from Nether Wallop DGH,' wherever it is, he says, 'You want to share your pain with me, my friend? I've just had to preside over the closure of the best unit in London, so what's your problem?''

Reference 142, SHA Manager 1

These two leaders collaborated to use their different positions, power bases and respective credibility to further the goals of the reconfiguration within their different (and crucial) peer

groups displaying impressive political awareness. The Clinical Director is responsible for reviewing the Pan-London Audit SINAP data:

‘[The Clinical Director] asks for a copy of the full report for every provider, for each quarter, which I think is like – a bit mind-blowing. NHS London see it at a London level. So what we do is, we consolidate the performance of all of the providers into one pathway, we report the model as a model. So we say London’s hitting this marker, London is hitting this. And we add everybody together.’

Reference 143; Network Project Manager 3

He effectively performs the role of a kind of clinical panopticon for stroke services and feeds the performance data back to the SHA and PCTs highlighting a hybrid professional and managerial form of identity:

‘I think everybody worked together as a group and I think the [clinical/managerial] differences in where we come from were not relevant really’

Reference 144; Doctor 1, Clinical Expert Panel

Both the strategic and clinical (or management and professional) leadership teams shared a commitment to improvement through standardisation based on a central belief in the value of measurement of organisational and clinical processes and outcomes. This was built around the increased surveillance regimes and data collection. However, the dictatorial ethos

expressed in reference 141 (relating to the management of managers by managers) implied by increased control is not replicated for professional staff – interestingly – as described at *Kenworthy* – the new framework of the London model in which professional staff find themselves operating, though much more standardised, protocol driven and generative of mountains of audit data is perceived in productive, or even ‘liberatory’ rather than disciplinary terms:

‘I saw [a stroke consultant] months back now and he’d just had his week on call in a HASU, and he said it’s absolutely fantastic, because the whole, all the systems, all the processes, all the staff are in there, ‘And I go in and I do my doctoring bit. That’s all I have to do, because the rest of it works.’ So he felt it was a freeing up to enable him to be a really good doctor as opposed to the senior person around having to worry about everything. So I guess, I guess it depends a little bit on what you – so, for [Doctor 1], who’s grown his unit over years, you can see how he might feel that some of that responsibility and accountability is taken away. But for people who always felt that was a burden as opposed to a privilege, it’s very, very liberating for them... But it’s really interesting about increased surveillance implies that other people are doing it to them as opposed to people own it for themselves.’

Reference 145; SHA Manager 2

‘[I]n some ways [I feel my autonomy is] augmented [by the stroke reforms], because I have the authority of the Trust to basically drive through things that I feel are urgent, urgently. So I suppose if you didn’t agree with it, I suppose my autonomy is

threatened by the four hour [A and E Target] wait, but it's probably not threatened by [the stroke reforms], but that's because this aligns with our clinical priorities, whereas the other thing doesn't.'

Reference 146; Doctor 6, *Kenworthy* hospital

References 145 and 146 express very effectively how increased control over organisational systems which previously were beyond the remit of clinical staff 'calms the water' through which they operate and increases their ability to perform their roles to new high standards. This is ethically rewarding and represents the fulfilment of desire for these clinicians rather than an external imposition of discipline. As the manager who delivers reference 145 concludes – where those operating within increased systems of surveillance feel they 'own' the data used to survey themselves, regimes of audit and surveillance may become practices of freedom rather than domination – in Foucauldian terms, discipline may be reconsidered 'as the price we have to pay for realising desire' (McKinlay and Starkey, 1998, p237).

This goes to the heart of why such burdensome audit has such acceptance and support from some clinical staff. The following exchange with a Network representative is revealing of the ethos behind the increased surveillance regime:

Informant: 'If someone's been flagged against a performance marker [i.e. a hospital is performing poorly], we'd look firstly at the volume of patients. If it's only four patients and one of them is not missed, it's very difficult to performance manage a Trust based on that. If you're talking 250 patients...

Interviewer: *This is quite interesting, the language, ‘performance manage a Trust,’ do you see it that way rather than ‘performance managing clinicians’?*

Informant: It’s definitely a Trust approach, I think... Because it depends on what measure you’re talking about. And mainly because the clinicians and the clinical teams want to meet the performance measures. So if there’s a barrier to meeting them, it probably hasn’t come from [the clinicians]’

Reference 147; Network Project Manager 3

The primary subject of surveillance is the organisation rather than the clinical stroke team. For this reason the increase in the disciplinary nature of the reconfigured regime of practice for stroke care is designed to enable the clinical staff to provide excellent care for patients – hence there is little clinical resistance to increased managerial control. The second key issue which mitigates the perception of control is the freedom to innovate locally within the pan-London disciplinary framework:

‘Well it’s [the model] very, very restrictive, which I think is a good thing in terms of these are the performance standards. There’s no negotiation, there’s nothing to talk about, there’s no room for manoeuvre, which is brilliant. I mean I probably, I’m the sort of person who likes a bit of structure within which I can then innovate... But, so things like we have to deliver thrombolysis within 30 minutes. How we do that is up

to us, down to the things like every patient leaving the ward has got to have a joint health and social care discharge plan. You know, how we did it, how we organised it, what it looked like, was entirely something we could create.’

Reference 148; Clinical Services Manager for stroke, *Kenworthy* Hospital

Therefore there is a creative element to the model for some clinical staff – they ‘own’ processes and can innovate and develop their knowledge and competencies at the local level – they have the requisite ‘space of action’ (Daudi, 1986; Fairhurst, 2009) in which to ‘enact’ (Mykhalovskiy, 2003; Ferlie and Fitzgerald, 2005) the extensive new evidence based protocols whilst their involvement in increased data collection subjects their organisation to Pan-London oversight – effectively protecting stroke specialist staff.

7.5 Summary

The chapter discussed the impacts of the implementation of the new regimes of government linked to the stroke reconfiguration programme at *Kenworthy* hospital. It was important to do this so that a picture of micro-level implementation could be aligned with the macro-level data collected as part of the thesis. The importance of a historicist (Bevir, 2010) approach was emphasised which highlighted the traditional comparative weaknesses of nursing and strengths of AHP and medical care delivery in stroke care at the hospital. An interesting finding was the impact that the HASU upgrade had through increasing the profile and importance of stroke care and by implication the jurisdictional power of the stroke care team to influence internal decision making and protocols (Abbott, 1988; Pickard, 2010).

The impacts of rapid increases in staff specialising in stroke care at *Kenworthy* were then discussed and the ways in which the ‘project of stroke specialisation’ for different staff groups impacted in different ways upon nurses, AHPs and doctors. Resistance to the new regimes of practice (Dean, 2010) was shown to be difficult (Newman, 2001). This was closely aligned to the increased regimes of management and measurement (Ferlie et al, 1996; Noordegraaf and Abma, 2003) which had disciplinary and ethical impacts on staff through the imposition of expressly evidence based guidelines and targets. The chapter demonstrated how the goals of senior clinicians and senior strategic managers coalesced – both communities internalising the importance of measuring both clinical and organisational performance and holding hospital management to account. Thus increased surveillance – transcending management ideology and becoming central to professional practice, whilst potentially having negative impacts for lower status staff (Anthony, 1977) could simultaneously be presented as a productive force rather than merely a disciplinary one (Brown and Lewis, 2009; Iedema and Rhodes, 2010) for members of the new specialist stroke team. This led to a discussion around the changing understanding of clinical autonomy for medical professional (Freidson, 2001; Armstrong, 2002; Timmermans and Berg, 2003) working under evidence based protocols.

Finally the key roles played by the stroke networks were discussed in relation to the effective implementation of the reconfigured stroke model for London. The ‘soft power’ of the network directors was noted – they utilised ‘peer-pressure’ and indirect governance techniques – nevertheless this coexisted with the top-down ‘hard power’ of the senior SHA management team which did have a strong level of control over senior managers at the Trusts

and PCTs – this highlights the complexity of New Labour governance arrangements (Rhodes, 2007; Pollitt, 2013) and the ways in which different ways of ‘governing’ may be coterminous (Lowndes and Skelcher, 1998; Newman, 2001). It was shown how Trust level management was able to reflexively use the network as a ‘bogeyman’ to further the jurisdictional claims of stroke care within *Kenworthy* (Abbott, 1988) and the importance of the legitimacy of the clinical director in aiding the work of the network.

These points will be explored further in the next chapter which offers a more comprehensive discussion of the theoretical and empirical insights offered by the thesis as a whole.

Chapter VIII

Discussion

8.1 Introduction

The central aim of this thesis as set out in the introductory chapter is to provide answers to this research question:

What was the role played by evidence in the reconfiguration of stroke services in London?

The aim of this discussion chapter is to draw on the data collected for the thesis in conjunction with reviewed literature to respond to this research question and extend empirical and theoretical understanding. The data collected for this thesis highlight that clinical evidence *of* and *for* practice were central to the development of a new framework of understanding, or *episteme* of stroke care in London. The operationalisation of the new *episteme* was an important factor in the implementation of the reformed regimes of government (Dean, 2010) of stroke care in London and influenced a significant part of both professional and management discourse and collective decision-making through the process of the reconfiguration (Spurgeon et al, 2010).

This process may be broken down into three stages for analytic clarity. This is reflected by the narrative logic of the three empirical chapters and the sections of this chapter. The first stage drew upon clinical evidence in the form of international and national audit and registry data and academic studies – this framed perceptions of the problem of stroke care in London and the potentiality of solutions. Section one of this chapter focuses on the key role of professionals and clinical evidence in shaping the new episteme of stroke care in the capital. It also includes a discussion around the theoretical implications of considering service reconfiguration in biopolitical (Foucault, 2007) terms. It draws primarily on documentary data and key informant interviews to do so.

The second stage of the reform programme drew on organisational metrics (both clinical and managerial) about current and future potentialities to show how different institutions could meet the criteria of the new episteme. Section two of this chapter examines how management control over stroke care in London was increased as part of the reconfiguration process by opening up stroke care to a central organising gaze in new ways. It explores the complex relationship amongst managers and professionals and how this might best be understood. It draws on interview and observational data as well as NHS London documentary data to do this.

The third stage of the reform programme relied upon ongoing LMDS and subsequent SINAP data to measure performance of providers against the agreed requisites of the new episteme. The third section of this chapter then discusses how the reframed episteme and new management techniques - based on principles of specialisation and standardisation of stroke care - impacted on staff subjectivities at the pan-London and hospital unit level. This section

draws on observational and interview data— especially local level interviews with staff at *Kenworthy* hospital.

8.2 Section 1: The role of evidence: increasing control through a reframed *episteme*

The drive to regularise the frame of reference through which stroke (as a condition) was (re)-conceived by patients, professionals, politicians and managers drawing on particular and specific 'encoded knowledge' (Flynn, 2002) had the effect of reifying stroke into a specialist emergency condition with strict standardised protocols throughout the city. In this way the London stroke reforms may be seen to demonstrate elements of EBHC as a power/knowledge nexus. A power/knowledge nexus is an 'ensemble of institutions, associated knowledge bases, techniques and practices' (Ferlie et al, 2011) which influence regimes of government and practice (Dean, 2010). EBHC represents a new manifestation of power/knowledge which may be seen to shape clinical practice and impact upon management techniques in specific ways (Dopson and Fitzgerald, 2005). Whilst the concept of EBHC as a power/knowledge nexus has been explored at a macro-level (Shaw and Greenhalgh, 2008; Ferlie and McGivern, 2013) its impact and functionality remains relatively unexplored at meso- and micro-levels.

An advantage of the present study is that it tracks the roles played by leading stroke professionals, boosted by international networks which placed them central to the epistemic community of stroke specialists. In effect, the data collected for this thesis permits an analysis of the power/knowledge nexus in action in a specific time and place – from problematisation

to delivery. A number of the key informants interviewed for this thesis were senior London based stroke clinicians involved not only in advising Professor Darzi on stroke for his initial review, but also in planning, developing, implementing and monitoring the delivery of the reconfiguration. These professionals – closely involved with the Clinical Expert Panel and subsequent pan-London Stroke CAG represented a specific ‘community of practice’ (Wenger, 1998; Ferlie and Dopson, 2005). Prior to and in conjunction with this, many of them had been involved in the production of internationally significant research, as well as work of the stroke specific audit work of the RCP, and guideline production via NICE.

The section below begins by considering the mobilisation of evidence *for* practice; then the use of evidence *of* practice in the construction of the new stroke episteme in London and the development of the new power/knowledge nexus in the capital.

Evidence *for* practice

Evidence *for* practice includes published, academic studies with high credibility such as RCTs, systematic reviews, and other protocolised guidelines emanating from professional bodies such as the RCP, the Department for Health, or quasi-governmental bodies such as NICE (2007). It also includes localised and regional guidelines which adapt these – for example alongside the London Minimum Data Set. These sources of data prescribe best practice for providers and are referred to in appendix A.

In the first stage of the reconfiguration the role of clinical evidence in the form of international and national audit and registry data and stroke research findings were central. These were used to legitimate the reification of stroke as an emergency condition which can be successfully treated – but all too often historically was not (see references 5, 6, and figures 4, 5, 6). This type of evidence was crucial to the reconfiguration because it enabled the establishment of a well-defined, professionally mandated understanding of a specific episteme for stroke care in the capital. This use of epidemiological knowledge effectively strengthened professional values (Numerato et al, 2011). Allied to this, RCP stroke audit data was used to highlight national and regional variations in care to show the failure of standardisation efforts, and patient and carer narratives were given prominence (NHS London, 2007; 2008b).

The use of such techniques to shape policy resonate with the findings of Ferlie and McGivern (2013) in their exploration of NICE's work as part of a power/knowledge nexus in that we see a bounded pluralism, use of international research networks and dominance of leading professionals. There is also recourse to an 'inspirational rationale' or ethical imperative for professionals to achieve evidence based care and a commitment to 'transparency' (Pickard, 2009) in methods used to achieve this (Ferlie et al, 2011). Together, the Framework for Action and the Acute Stroke Strategy for London (NHS London, 2007) publications utilised evidence from clinical research allied with both professional and public feedback to problematise (Dean, 2010) stroke care in London in a specific way. This highlighted the potentialities of highly technologically advanced medical interventions (for example, thrombolysis) and targeted the traditional barriers of poor hospital organisation and management (see chapter V).

Moreover, the clinical authorship of these documents was heavily emphasised so that the (appearance at least of the) problematisation of stroke care inadequacies in London became one of *professional* expertise rather than *political* or *managerial* decision making in contrast to both the Tomlinson and Turnberg Reports (see the first section of chapter V). In this way, the perceptions of the problems that hindered effective stroke care and the prospective solutions were tightly managed and closely controlled within a specialist, professional discourse (Weiss et al, 2007). There was no talk of financial rationalisation, or the need for mergers in contrast to the text taken from the Tomlinson and Turnberg Reports respectively (see references 1 and 2). Rather the language used in the health care for London literature was more centrally fixated upon a form of Discourse that emphasised the importance of clinical evidence (and implicitly, a form of rationality compatible to both professional and managerial stakeholders) and the pursuit of excellence (for all) – expressed by the recourse to phrases such as ‘World Class Care’ (Darzi, 2007). This is in contrast to other reconfiguration processes which are precipitated through an explicit desire to reduce costs (McKee and Healy, 2002; Brown, 2003; Parkinson, 2003). There was an ethical commitment to tackle health inequalities alongside promises of economic efficiency in biopolitical (Foucault, 2007) terms – combining claims to both moral and cognitive legitimacy (Oborn, 2008).

This evidence based Discourse posited a dual economic and ethical rationality (Ten Have, 2000), marrying both neoliberal and social concerns. EBHC as a power/knowledge nexus thus offered a ‘subjectifying logic’ (Martin et al, 2013) which utilised managerial (economic) rationality and professional (ethical) values and emphasised their compatibility (Southon, 1994; Numerato et al, 2011). It had a rhetorical power which discouraged dissent (Goldberg,

2006) and a legitimating power which enabled its proponents to establish jurisdiction over specific fields of practice (Abbott, 1988; Timmermans and Berg, 2003).

Professionals were charged with identifying the problems and designing the solutions – aided by project managers from NHS London and external management consultants. The values of transparency and calculability (Pickard, 2009) (see reference 14) were emphasised along with a sophisticated understanding around how to use emotive narratives (see reference 11) and the quasi-independence of charity groups (see reference 23) to engender lay support for change (Oborn, 2008). EBHC as a power/knowledge nexus here functioned by emphasising how variation in outcomes was both ethically problematic and practically solvable.

Population level data and the power of numbers (Rose, 2006) made stroke care performance visible – highlighting variation and underlining the need for standardisation (Timmermans and Berg, 2003). Peer-pressure was used in both formal and informal terms to promote elements of competition and collaboration between professionals and institutions.

Public consultations were performed in relation to the Darzi recommendations and stroke reconfiguration reforms in London. Meetings were held in public arenas and minutes published and detailed on the website of NHS London. PCTs and local authorities were invited to vote on the acceptability of reconfiguration plans. Third sector organisations were invited to be involved in the reconfiguration process, and patient voices were intended to be heard through selected ‘patient panels.’ (Farrar et al, 2013). Whilst the above appears to have elements of deliberative democracy (Dryzek, 2000) or ‘associational democracy’ (Hirst, 1994; Newman, 2001) the data gathered as part of this thesis suggests that in reality, citizen, or community power and public participation was really rather minimal and effectively

managed by the dominant managerial and professional forces involved in leading the reconfiguration – this is a consistent finding in studies of mergers and reconfigurations in the health sector (Spurgeon et al, 2010; p18).

The SHA leadership drew on Management Consultancy project management skills (Hood, 1995) to shape the consultation processes which effectively ensured stakeholder agreement to plans which the central team had already made (reference 28). In this way, the promotion of a coherent episteme based on clinical stroke specialist evidence and persuasive project management skills took the politics (and hence the contention) out of the subsequent public consultation and JCPCT decision making processes. As with the stroke charities and ‘expert’ patient panels – their independent input was based around legitimisation of professional and managerial decisions and thus aimed at minimising dissent. In this way, the dominant Discourse of evidence based stroke care may be seen to have conflicted with that of the ‘patient voice’ (Komporozos-Athanasiou et al, 2011) and whilst EBHC opened a window on clinical decision making for managers (Hasselbladh and Bejerot, 2007) it did not do so for the public.

Evidence of practice

Evidence of practice included audit and performance data focused on both clinical and organisational markers. Decisions around both these forms of evidence: what was published and when, who published it and how it was used; were political decisions collaboratively made by both professional and managerial stakeholders, and together they manifested a new

‘truth’ (Dean, 2010) about what stroke was, and what ‘good’ and ‘poor’ care would consist of.

The clinical academic elite leaders emerging at the summit of the developing power/knowledge nexus (Ferlie et al, 2011) of the London stroke programme were willing to highlight fellow professional failings. Likewise, senior SHA managers were willing to signal organisational (or Trust management) weaknesses which were hindering stroke care in London (references 18 and 19). This dual identification of both professional and managerial inadequacies – in effect, evidence *of* practice - in stroke care services legitimated a new, increasingly disciplinary regime based on the dual principles of eliminating ambiguity (Noordegraaf and Abma, 2003) around exactly what stroke professionals should deliver as ‘best’ or evidence based care and an extension of the performative transformational power of transparency and calculability (Dean, 2010) for organisational performance.

The London stroke reconfiguration is best seen as a coordinated city-wide programme of reform aimed at transforming the regimes of government (Dean, 2010) of health care professionals and managers throughout the NHS in London. It is part of a larger process (Spurgeon et al, 2010) built on previous national programmes aimed at reform going back to the 1980s and the professionally led push for recognition of stroke as a new sub-speciality, and clinically significant advances such as the evidence base around thrombolysis delivery that emerged in the 1990s. It drew on the ongoing RCP sentinel stroke audit and the National Service Framework for Stroke, the National Audit Office report of 2005 and crucially the 2007 National Stroke Strategy which formalised stroke as a speciality and committed to extra funding and the principles of specialisation (see Appendix A).

An interesting aspect of this macro-level push for ‘specialised’ status for stroke care, perhaps replicated in the London reforms was the marginalisation of therapies evidence for practice (Sudlow and Warlow, 2009) and the dominance of medical evidence for practice which shaped the new episteme in a particular (acute care) fashion (see references 30, 31 and 32). The ‘scientific colonisation’ of health research ensured that the ‘dominant model of scientific discovery being associated with medical, pharmacological or biotechnical worlds’ (Shaw and Greenhalgh, 2008) prioritised acute care developments with strong evidence bases such as thrombolysis delivery ensuring that the majority of time effort and money involved in the reconfiguration focused on highly dynamic medical interventions – at the expense of less well-evidenced therapeutic rehabilitation options.

In this way, the shaping of the new episteme may be seen to have furthered medical dominance- specifically the position of academic clinical elites (Freidson, 2001; Armstrong, 2002) at the expense of therapy communities in jurisdictional terms (Abbott, 1988). Credibility and ‘knowing’ is embodied within certain practices and communities which may serve to underscore traditional hierarchies and social positions (see reference 35). Likewise the institutional concerns of acute care providers were able to take precedence over community care providers – signifying the structural dominance of the acute sector over that of the more fragmented community and primary care sectors (see reference 34).

Key senior medical informants interviewed for the thesis had been involved in guideline construction and audit rollout with the RCP and NICE and had links with one or more of the

key ‘independent’ stroke charities. To lesser or greater extents, these clinical experts were or had been involved in the production of internationally significant research into stroke, and had also had influential editorial pieces published in high impact journals. Their roles as experts were cemented by academic success and a political ability to engender trust through their actions. This made them credible stakeholders in clinical and academic terms - such professional credibility is linked to social positioning (Ceci, 2004). Their involvement in audit and regulatory redesign may also instantiate (elite level) professionals actively shaping clinical practice through ‘re-negotiated mechanisms’ of control (Broom et al, 2000; Herk et al, 2001; Weisz et al, 2007).

Senior SHA managers were aware that without the credibility of these clinical leaders with both structural and normative legitimacy (Lockett et al, 2012) then their efforts at reform could be compromised (see references 4 and 5). The leading clinical experts enrolled (Osborne, 1993) into the reconfiguration were likewise aware that without the patronage and power invested by the senior SHA managers, their ability to influence (stroke service) change at a pan-London level was considerably weaker (see references 15 and 16). In this way, elite clinicians and senior strategic level managers have a symbiotic relationship: effective health service management requires clinical knowledge, experience and legitimacy. Reciprocally, professionals (especially those representing emergent sub-specialisms) require strategic managerial or governmental power to aid their jurisdictional battles (Abbott, 1988; Johnson, 1993; Pickard, 2010) within the broader system. Leading stroke professionals thereby appeared willing to subordinate the clinical autonomy of their (less senior) colleagues in order to secure and increase the professional autonomy of stroke as an emerging discipline (Armstrong, 2002; Timmermans and Berg, 2003) utilising an evidence based Discourse which emphasised improvements in patient care.

The establishment of the clinical expert panel, and its significant overlap with the project board as part of the reconfiguration was crucial in creating an institutional framework for ‘truth production’ (Dean, 2010) and rules of understanding (Ceci, 2004). The London stroke reconfiguration highlights that EBHC as a power/knowledge nexus may become self-perpetuating by setting the context through which policy was shaped, understood, developed, and subsequently reviewed and then amended. In this way, clinical experts mandated best practice - drawing on the emergent grey sciences of information science, systematic review and health economics as identified by Ferlie and McGivern (2013). However, other techniques to secure ‘moral legitimacy’ (Oborn, 2008) were utilised in this process – stroke charities for example were incorporated to add an element of ‘independence’ and the support of the ‘patient voice’ (see reference 29) to these processes potentially upsetting rational evidence based transfer discourse (Kompouros-Athanasiou et al, 2011). Furthermore, certain metrics relating to evidence of performance were selected to highlight the variability of service provision in the capital and also point towards strategically significant ‘quick wins’ (see reference 8) as new markers by which to evaluate the effectiveness of the reforms – key amongst these would be thrombolysis rates, stroke specialist unit admission rates, and average length of stay (Rudd, 2012).

The section above highlighted how a new episteme of stroke care was developed for the capital which successfully painted the prospects for reforms in a positive light for all stakeholders; it built on previous historic programmes to reframe stroke care, drew on the establishment of a nascent Pan-London power/knowledge nexus (Ferlie et al 2011) using EBHC principles to justify strategic change, and crucially served to *control perceptions* about

how to effectively improve local stroke services. The language of EBHC depoliticised the political nature of strategic decisions (see references 28 and 29). EBHC offered a legitimating Discourse to justify contentious decisions which shaped the way agents responded to policy developments (Fairclough, 2000; Dopson and Fitzgerald, 2005; Oborn, 2008). The data in this thesis have shown that some of the decisions presented as ‘evidence based’ were often only loosely, or partially so – rather, representing an ‘expert consensus’ (Klein, 2000; Nutley and Davies, 2000) (see chapter V section 3). However, at a macro- or meso-level (pan-London) an emphasis on the evidence based nature of the reforms limited dissensus, whilst at a micro-level (*Kenworthy* hospital) it would come to justify cultural changes to the approaches professionals used to care for stroke patients. This is explored theoretically below.

Conceptualising service reconfigurations as ‘practices of security’ is useful because as with the application of the Discourse of evidence based health care, such concepts may depoliticise potential and real political resistance to change. By building on Foucault’s (2007) four notions; case, risk, danger, crisis which were introduced in chapter III; and applying empirical data from the London reconfiguration this section seeks to theoretically extend understanding of reconfigurations as particular biopolitical interventions.

First comes the ‘case’; specific diseases only become conducive to biopolitical interventions at certain points in time – this is linked to scientific knowledge and the development of evidence. So there needs to be sufficient data on incidence rates, research on causes and effects and treatment options, international comparisons – all research *for* practice in other words – as highlighted in chapter V section 1; and figure 8 and reference 7 in particular in relation to stroke care in London. How the case is defined is important. The work of NHS

London in making stroke visible as a particular *London* problem through the Darzi review and the Stroke Strategy documentation is illustrative of this.

Next, the ‘risk’ is calculated through analysis of research *for* and *of* practice. Audit data can be used to highlight actual morbidity and mortality rates – this may be RCP stroke audit data or HES data for example. As highlighted by figure 8, incidence rates can be graphically displayed to shape perceptions around where problems are located. This technique of manipulating epidemiological data is useful in expressing a conception of ‘danger’ whereby certain London suburbs with high concentrations of elderly (and some ethnic minority) populations represent communities for whom stroke is a greater risk than other communities. This permits an examination of health and social inequalities across a certain defined area and prioritises epidemiological data and statistical techniques.

The fourth factor is that of a ‘crisis.’ Unlike Foucault’s examples of leprosy, the plague or small pox, stroke is non-communicable. However the *construction* of a crisis is an important facet in generating legitimacy for reconfigurations – in clinical terms. The ‘crisis’ needs to appeal to the sensibilities of key stakeholders – for example, the sense of stroke survivors feeling ‘cheated’ by poor care as articulated by the charity representative in reference 23 is powerful in helping (alongside strong epidemiological and economic data) make the strong case for change.

The reconfiguration set out to, and may be seen to have achieved its goals (at a pan-London level and at *Kenworthy*) in transforming the way stroke was conceived at a London population level following this model of ‘case, risk, danger, crisis’ . Central was the ability to reframe the episteme related to disease; treatment; success and failure. Stroke became

reframed as a *London problem* – rather than a national problem (NAO report, 2005; National Stroke Strategy, 2007), nor a hospital or individual problem. This process is centrally concerned with discursive power leading to the establishment of new standards, or norms through which stakeholders can agree *how* to resolve the ‘crisis:’

‘[N]ormalisation is less concerned with establishing a model than with reaching an understanding regarding the choice of a model. The essential question is not the production of objects that can act as a standard but the establishment of procedures that will lead to a general agreement regarding the choice of norms and standards. In discourses of technical standardisation all norms of terminology, of spatial measurement and of quality are interdependent, and this interdependence arises from the fact that what is normalised is not a world of things but language itself’ (Dean, 2010; p141)

The Foucauldian concept of biopolitics then is useful in demonstrating how legitimacy for reconfigurations can be generated and establishing an agreed discourse, or language through which specific policy problems are understood and subsequently tackled. However, the concept is also of use beyond the ‘problematisation’ stage. The SHA management possessed a ‘biopolitical’ ethos as demonstrated in reference 9 ‘to make change happen... albeit “top down”’ change that may have riled some stakeholders; this included downgrading the best performing stroke unit in the capital – a symbolic act that highlighted that no institution was larger than the biopolitical goal of standardised care across the whole city. This process required a form of reflexivity in policy making and consideration of *how to organise care for* the population and a shift to ‘bat for 12,000 London stroke patients’ rather than institutional interests (reference 71).

Through the reconfiguration and implementation process, as the generation of data increased, the focus was not just on the patient level data – but upon the professionals and managers too. This required professionals to recognise the legitimacy of the programme, and it also required technological innovations to monitor institutional behaviour. The biopolitical approach established and then legitimated ‘government at a distance’ (Dean, 2010) to monitor the agreed norms and standards once agreed. This reconfiguration was not carried out centrally – in that the Department of Health was ‘hands off:’ rather it had devolved biopolitical responsibility to the SHA to manage the care of Londoners. Reconfigurations which successfully draw on the Discourse of evidence based health care, such as the London stroke service reconfiguration may serve to depoliticise resistance because service changes function as ‘biopolitical’ interventions and therefore garner moral and cognitive legitimacy (Oborn, 2008). This is important because it realigns traditionally antagonistic goals.

The next section focuses on how the new episteme of stroke care in the capital was operationalised to *control the response* of clinical and managerial stakeholders whose work was to be transformed by the reforms.

8.3 Section 2: Increasing managerial control of the new *episteme*

EBHC as a power/knowledge nexus functioned as a policy tool to shape the reconfiguration by aligning and legitimating clinical, managerial, strategic and political stakeholders together around a common set of values (Sabatier, 1998; Oborn, 2008). Many of these values were

articulated explicitly in official documentation and cluster around an ethical drive to improve patient care and outcomes centred on augmenting ‘caring’ practices (Dean, 2010) influenced by scientific knowledge and rationalist logic leading to a reification of stroke as a sub-specialism which impacts upon both clinicians and (hospital and commissioning) managers (see p5 of Preliminary Stroke Strategy for London – NHS London, 2008). These values were underpinned by management practices which focused upon the construction and removal of organisational barriers to this prior-identified ‘best care’. Rather than being presented as antagonistic to professional values – the ‘compatibility’ of economic efficiency and bounded competition for example and were seen to serve and guarantee new forms of professionalism, validated standards and autonomy (Southon, 1994; Joyce, 2001) together with a focus on improving patient outcomes.

The techniques utilised to promote the adoption of these values focused upon limiting dissent, controlling professional responses and increased surveillance. This was implicit, and was not prominent in the official literature. An interest in these techniques emerged more from the data collected in interviews and observations. The latter of these proved to be heavily concerned with how to ensure stricter compliance with the new care protocols and achieve increased data returns and to formally and informally report back to central powers on adherence to the new regimes of government.

There are two major themes explored in this section, firstly, the push towards greater managerial control and oversight of stroke service provision in the capital and the techniques used to establish this; and secondly, the impacts that these processes had upon inter-professional and professional-managerial relationships and subjectivities.

Furthering management oversight

The reconfiguration process opened up stroke care in London to the centralised gaze of management in new ways establishing new regimes of government (Dean, 2010). In the first stages of the project as described in the previous section (problematifying stroke care in the capital, and then devising a strategy to improve care) the goals of powerful (medical) professionals advising senior SHA and PCT managers were closely aligned and highly compatible with each other (Southon, 1994). They had a shared understanding about the direction of travel they wished to pursue in stroke services and agreed about the broad shape they wanted the reconfigured service to have – a reduced number of increased specialist centres (Ferguson et al, 1997; Farrington-Douglas and Brookes, 2007) delivering evidence based stroke care centred around the mantra that ‘time is brain’ (Gomez, 1993; Saver, 2006; Baeza et al, 2012a) prioritising thrombolysis delivery and stroke unit care.

Whilst, (as highlighted in references 31 and 32) there was a dissonance between the perceived credibility of the medical and AHP claims to legitimising knowledge and deployment of evidence (Ceci, 2004), until the site selection controversy (see chapter VI section 1) there was no breakdown between professional and management stakeholders at the centre of the process. Both groups professed an interest in calculability and increased measurement along NPM lines (Hood, 1991; Ferlie et al, 1996; Pickard, 2009) in the pursuance of standardisation and improvement (Timmermans and Berg, 2003). Hence the unity of purpose in how the problematisation of London stroke services was framed, and the agreement around the process of managed competition process for HASU status. Chapter V section 3 demonstrated how the consensus for change was established; drawing on

management consultancy skills lent legitimacy by patient association support. The lack of definitive clinical evidence behind the superiority of any of the three proposed models (Klein, 2000; Nutley and Davies, 2000) was also discussed and the reality that organisational and skill set (staffing) concerns (Spurgeon et al, 2010) were central to the modelling process.

The HASU site selection process was based on two evaluative criteria: the bid evaluation and the configuration evaluation (see figure 11). The effect of the bid evaluation was to open up stroke management procedures for clinical care and organisational prioritisation of the London hospitals bidding for stroke specialist status to the gaze of the SHA, networks and other coordinating stakeholders such as the stroke CAG. This in effect created a new practical evidence base that was of benefit to both the clinical and managerial stakeholders driving the process from the centre. The bid evaluation process required NHS Trust level management to describe and commit to how they would meet the new designation criteria for reconfigured stroke care. This entailed extensive documentation around clinical quality, continuous improvement and network working commitments. The production of such documentation was only achievable by submission to the new regime of government which represented an explicit acceptance of the new stroke programme (Dean, 2010). Hospitals were free to compete with each other for the right to provide the new service – however, they would be successful only by conforming to the strictures of the new orthodoxy of care as inscribed by the clinical experts and authorised by the strategic managers.

In this way, competition between London's providers was encouraged, but in the service of standardisation rather than variance reflecting the complexity of New Labour governance arrangements (Newman, 2001). This was welcomed by stroke clinicians (at both elite

(strategic) level and at *Kenworthy*) because it raised the profile of stroke and increased its importance within an institutional context. Evidence based clinical guidelines became significant for senior hospital managers with respect to stroke care in a new way (and potentially for some trust managers for the first time) – thus a regime of increased calculability could be seen to serve and further professional interests (Iedema and Rhodes, 2010).

Increased baseline and projected data collection related to provider performance was thereby welcomed by stroke professionals as it was perceived not as a managerially led invasion of clinical autonomy, but a safeguard for ring-fencing minimum standards (and an assurance of staffing levels and investment in stroke care). In this way it has resonance with the concept of strategic adaptation, or reverse managerialisation (Waring and Currie, 2009) and serves as an example of an emergent professional sub-specialist group willing to develop clinical practice guidelines in order to increase its own jurisdictional power (Timmermans and Berg, 2003).

An example of this was articulated by the *Kenworthy* Clinical Services Manager at one of the Clinical Advisory Group meetings where she argued for the continuation of strict ‘peer review inspections’ involving Commissioners, Network officials and senior clinical leaders from neighbouring Trusts. She argued that these were a valuable organisational tool for her because they maintained the visibility and profile of stroke services at *Kenworthy*. She therefore wanted them to continue beyond their scheduled phase concerned with embedding the new regime of practice (Dean, 2010).

For professionals working in stroke care, this then meant that increased surveillance could be presented as a productive rather than an exclusively disciplinary force (Brown and Lewis, 2009; Iedema and Rhodes, 2010) and was therefore less likely to be met with resistance. Senior Trust level managers also welcomed this surveillance because it was linked to increased financial rewards through raised tariff payments and allowed them to meet their data reporting and patient outcome commitments. Increased levels of evidence and data would be perpetually required of the trusts and produced by them to regulate performance and demonstrate compliance with the new regime of government (see references 73 and 74).

At the same time however – the increased pressure of surveillance increased the demands on both professional and managerial stroke specialist staff at *Kenworthy*. This disciplinary force impacted upon both higher and lower status staff (as demonstrated in chapter VII).

Furthermore, the ethical imperative of the Discourse of EHBC meant that counter conduct (Dean, 2010) lacked a credible narrative inhibiting resistance against the new dominant clinical-managerialist position (Newman, 2005). In this way, a ‘management ideology’ which permeates the subjectivities of staff so effectively – binding them into restrictive practices from which they cannot dissent may become pervasive with possible problematic connotations –especially so for lower status staff (Anthony, 1977; Martin and Learmonth, 2012).

The developing London *episteme* of stroke care (in the form of evidence and data measured against ‘best practice’) became ever more deeply embedded as a central apparatus of control. Whilst in some ways EBHC and NPM share a difficult relationship with often conflicting goals (Hood, 1996), these data pointed to a shared reverence for the power of numbers and

the value of rational measurement systems and ongoing audit (Ferlie et al, 1996; Power, 1999; Dunleavy, 2004; Rose, 2006) in establishing mutually accommodating frameworks to control how health care professionals and managers responded to and interpreted changing clinical and organisational priorities. Verifiable data on an increased number of interventions in stroke care was a key resource enabling senior professionals and managers to shape and then run the reconfigured service (see reference 93) at both the meso-level (pan-London) and micro-levels (Stroke Unit).

The LMDS was introduced and monitored by the clinical networks. It was initially seen as a project management tool to ensure adequate progress towards the new clinical and organisational goals. However, through the process of implementation, the monitoring continued and was transformed into a real-time performance management tool reporting centrally to the RCP in the form of SINAP (see reference 76). The clinical director of London stroke services (also the clinical lead for the RCP Sentinel Stroke Audit) came to receive reports in real time on all the acute stroke admissions across the capital detailing over 100 data codes covering the first 72 hours of an admission (see Appendix C). The RCP then possessed the power to cascade reports down to networks, trusts and commissioners and also publish named hospital reports on its website for public view. This is a further example of the ‘circularity’ of EBHC as a functioning power/knowledge nexus (Ferlie and McGivern, 2013).

The position and power wielded by the RCP was enhanced as it controlled much more detail on the practice of clinical teams and by implication hospital management arrangements than ever before through professional control of the audit (Broom et al, 2000; Herk et al, 2001). This detailed knowledge of individual hospital performance, held by and interpreted by the

RCP significantly empowered (elite members of) the profession (Armstrong, 2002). In this sense, the data could be used at a micro-level as ‘measurement for improvement’ amongst, across and within clinical teams, but it could also be used politically to push for change as ‘measurement for judgement’ (Berwick, 2001; Timmermans and Berg, 2003) through commissioners. The increased surveillance and use of audit represented a form of colonization (Power, 1999); and ‘active professional involvement leading to soft autonomy’ drawing upon Levay and Waks’ (2010; p523) ideal typology. This also enabled the medical profession to influence nursing and AHP practice by setting the parameters of the data collection and thereby establishing what was considered best practice in stroke care with respect to not only medical, but also nursing and therapies practice.

Managerial-professional relations

Whilst there is a focus in much of the literature on the conflictual relationship between managers and professionals (Numerato et al, 2011), the data generated by this thesis suggests that the definitional distinctions between ‘professional’ and ‘managerial’ identities were amorphous; those within each group were significantly stratified; and the relationships themselves were more consensual than conflictual in nature. The narrative in London was *not* of managers imposing change on reluctant clinical staff which set each community neatly against each other. Rather it was of elite, structurally powerful strategic level managers enfranchising an efficient project management team alongside elite, clinically respected leading professionals creating a consensus around the clinical and organisational barriers which traditionally inhibited standardised high quality outcomes for patients in one specific clinical specialism. This led to a focus on challenging organisational (hospital level

management) practice in order to facilitate clinical practice change at the clinic level in pursuance of a quality health care system as a ‘collective good’ (Numerato et al, 2011; p638).

Observational data centred on the Clinical Advisory Group highlighted that whilst clinically led; the group was managerially focused – concerned with data metrics and committed to standardising professional practice through organisational protocols. In socio-cultural terms (Numerato et al, 2011), the professionals who constituted the panel may be seen to have been operating through a framework of ‘managerial hegemony’ in which performative management values were internalised, and management discourse had become elemental to their identities (Joyce, 2001; Doolin, 2002; Numerato et al, 2011) as professional leaders of the stroke specialist discipline. Hybrid, clinical-managerial roles blurred the lines between professional and managerial identities and positions fostering a sense of ‘compatibility’ between the two logics (Spooner et al, 2001; Dent, 2003). For example, the senior professionals who led the CAG all held managerial responsibilities at their respective units as *clinical leads*. Also the ‘non-professionals’ who attended the meetings –one a Network Director and the other a Clinical Services Manager – and offered the two ostensible ‘management’ voices at the Clinical Advisory Group meetings had both previously worked as AHPs and now managed full-time. As Doctor 1 noted (reference 144) it did not matter where stakeholders came from – the manager/professional distinctions were subordinate to the shared goals of improving stroke care.

This is significant because it highlights the positive nature of the relationships between managers and professionals in this instance and the shared sense of purpose and trust between the two communities. Whilst traditionally, epidemiological knowledge and EBHC has been

seen to play two oppositional roles in professional-managerial relations – on the one hand, it has been characterised as strengthening professional values by having a positive effect on clinical knowledge; whilst on the other, it has been seen as a harbinger of increased surveillance and augmented management control and thereby antithetical to professional values (Mykhalovskiy and Weir, 2004; Weisz et al, 2007; Numerato et al, 2011); these data suggest that the relationship does not need to be oppositional – rather, it is possible to reduce aspects of clinical autonomy whilst furthering professionals’ abilities to realise their ‘ethical desires’ and professional goals (Herk et al, 2001; Flynn, 2002; Armstrong, 2002; Timmermans and Berg, 2003).

The regimes of government developed as part of the London reforms of stroke care established new, increasingly authoritative professional hierarchies both at the pan-London and hospital unit level (Newman, 2001). The espoused ethos of ‘improvement through standardisation’ – of bringing performance up to a shared level of competence, through the development of a specialist stroke professional cadre focused exclusively on treating stroke patients required hierarchical relations and central oversight (Timmermans and Angell, 2001; Broom et al, 2009). New forms of professional and managerial supervision were introduced. New formal supervisory roles were developed which previously did not exist – for example, the position of regional clinical director for stroke and clinical network lead roles and increased unit level management as represented by the Clinical Services Manager at *Kenworthy*.

Alongside newly developed locally agreed protocols for controlling systems of care (Timmermans and Berg, 2003) and strict reporting mechanisms controlled by the medical

profession (Broom et al, 2000; Herk et al, 2001; Waring, 2007) the regimes of government developed here stressed the need for increased accountability of professional behaviours, increased control and central oversight which bolsters the jurisdictional power of clinicians committed to delivering stroke as a specialist discipline (Abbott, 1988) and the academic managerial elite within that group (Fitzgerald and Ferlie, 2000; Freidson, 2001; Armstrong, 2002;).

Formal authority was extended beyond senior professionally dominant clinicians however. The regimes of government developed as part of the stroke reconfiguration programme also depended upon the extension of ‘top down’ SHA executive power (Newman, 2001; Pollitt, 2013) distanced from the Department of Health (Moon and Brown, 2000). The SHA executive, significantly, was able to shape the priorities for senior PCT commissioners and (non-FT) hospital leaders and thus emphasise the strategic importance of stroke care developments by building this in to their annual Key Performance Indicators (see reference 141). This demonstrated strong hierarchical management power contra Dent’s (2005) claims for a post-NPM model based on freedom of NHS providers and organisations because even FTs had to accede to the demands of the SHA if they wished to gain accreditation to deliver the London stroke model. The actions of the SHA here were closer to Dunleavy et al’s (2006) concept of ‘reintegration’. This increased formal authority based on hierarchical control thus demonstrated elements of both professional and managerial dominance; greater managerial power and increased ‘hands on management’ (Hood, 1995), alongside a trend towards ‘informal’ aspects of authority as highlighted in relation to networks’ ‘soft power’ (see reference 138).

Returning to the concept of the power/knowledge nexus (Ferlie et al, 2011) it was possible to identify an integration of mutually compatible professional and managerial goals (Numerato et al, 2011). There was neither a homogenous ‘management’ position, nor a homogenous ‘professional’ position. Instead, there were different coalitions of managers, policy makers, clinicians and ‘hybrids’ who strategically drew on and shaped different aspects of clinical evidence and techniques of management at different points to influence the emergent regimes of government – within a framework which was accepting of rather than hostile to the values and potentialities of the managerialisation of professional practice (Joyce, 2001; Waring, 2007; Pickard, 2009). The reformed regimes of government (Dean, 2010) instigated NPM type (Ferlie et al, 1996) incentives focused at the hospital trust board level mandated through financial instruments (promises of greater funding and threats of lesser funding) demonstrating compatibility between professional and managerial goals through intertwined economic techniques and biopolitical (Foucault, 2007) goals which had strong professional support (Darr et al, 2003).

The regional stroke clinical networks acted as conduits of managerial and clinical imperatives – both formally and informally (Sheaff et al, 2004) and worked on the development and implementation of organisationally focused change and measured this on behalf of the SHA and commissioners. The networks started from a point of trust that clinicians desired to achieve improved outcomes for their patients (Sheaff et al, 2004; Numerato et al, 2011). The ethos behind the networks’ surveillance was that *Trusts* were to be performance managed – *not professionals* (see reference 147). The SHA emphasis was on changing the organisational context in which stroke care was provided as a joint initiative between managers and professionals on the understanding that the professional stroke leading elite would ensure that the performance of stroke clinicians at the hospital unit level would consistently meet agreed

standards. This was highlighted by the role of the CAG and the content of the meetings observed.

Therefore clinical and managerial goals were highly compatible – taking us beyond the resistance/control dynamic highlighted in other studies of health care governance change (Numerato et al, 2011). The picture painted by these data is much more nuanced then, and less conflictual – and crucially is not characterised by managerial change being imposed on reluctant professionals – but collectively and collaboratively led by managers and professionals together; thus making negotiation between stakeholders highly consensual in nature. The priorities of managers and professionals were not in opposition – they were negotiated through dynamic and evolving relationships that cemented the effective functioning of the power/knowledge nexus (Ferlie et al, 2011) and thereby the new episteme of stroke in London. The central, and perpetual nature of data collection ensured that new evidence of performance was constantly being generated and evaluated, discussed and compared, maintaining the importance of the central overseeing role of the networks and then the RCP. This may be seen to have represented professional self-monitoring and managerialised control ‘at a distance’ (Light, 2001; Sheaff et al, 2003; Foucault, 2007).

8.4 Section 3: Controlling the delivery: Specialising stroke care through the new *episteme*

These data suggest that the ‘ethos’ of the London reconfiguration of stroke services, building on the multiple reform programmes instigated at a national level to improve stroke care since the mid-1990s displayed what Dean (2010) terms a ‘non-subjective intentionality’ to increase

management control through a reified episteme which influenced how all stakeholders conceptualised stroke (both diagnostically and therapeutically) and sought to encourage them to use their situated agency (Bevir, 2010) accordingly by adhering to a more coherent regime of practice (Dean, 2010) in which evidence based ‘thinking’ and responses became ‘instinctual’ (Dopson and Ferlie, 2005). These regimes of government functioned as a ‘restrictive,’ disciplining power by inscribing explicitly how stroke patients are to be treated and measuring performance against these criteria closely. This was welcomed by stroke professionals however because they utilised this disciplinary power productively to enhance their jurisdictional position and achieve their ethical desires as stroke specialist professionals.

This is where the critical purchase of performing an analytics of government is established. No such ‘ethos’ is openly expressed in the Darzi review, nor the NHS London papers aimed at the public through consultation or the organisations as part of the site selection process. This ethos, or *logic*, emerges through analysis of observational and interview data which uncover *how* the protocols and audit regimes actively functioned. This new, heavily controlled regime of practice for treating stroke in London reified stroke ‘caring’ as an emergency concern, through which professional judgement was to a degree subordinated to protocols which were closely monitored and linked to financial incentives for Trusts. There is no evidence that such a policy was inevitable, rather government (as manifested through the reconfiguration process) appears to be a ‘constantly problematising activity’ (Dean, 2010) in Foucauldian terms, and it appears to be a dual (highly compatible) managerial and professional concern (Numerato et al, 2011). The new regimes of government which emerged from these processes emphasised increased monitoring, more management (and managers focused on stroke care) more measurement, more comparisons of performance, elements of

competition and collaboration at different times and within different contexts and a transformed type of clinical agency and professional identity (Newman, 2001).

The *specialist* nature of stroke care and a new type of stroke specific professionalism was emphasised which impacted upon the subjectivities and ‘identity work’ of staff working in the new services. This new specialist tenet simultaneously emphasised both the ‘standardisation’ at the heart of evidence based modes of delivery (Timmermans and Berg, 2003) which promoted a reproduction of strictly protocolised actions whilst encouraging staff to feel they had the space to ‘enact’ (Dopson and Ferlie, 2005) and elaborate upon the same guidelines. These complex phenomena are explored in turn in this section.

Specialisation and standardisation

By the time the reconfigured service went live across the HASU and SU sites from 2009 there was a well-established, episteme of stroke care based on the principles of specialisation (Pickard, 2010) and standardisation (Timmermans and Berg, 2003). Historic weaknesses, such as care of the elderly nursing standards at *Kenworthy*, were identified and innovative mechanisms aimed at transforming such practice were being developed and were sufficiently funded. A rapid uptake of stroke staff across multiple professional groups was incorporated into new specialist teams (see chapter VII sections 1 and 2). Non-stroke specialists (LAS, A and E and Radiology staff) were trained to prioritise and treat stroke patients in new ways which aided the rapid functioning of the new stroke care pathway. At the heart of these new regimes of government was a professional and managerial push to reduce the historical ambiguity and subsequent variability that care at the micro-level had faced in stroke. Senior

professionals and managers wanted through specialisation to create a ‘production line’ (see reference 78) generating standardised care for all London stroke patients during their time in hospital.

At an organisational level, the autonomy for staff ‘to [possibly] do things badly’ was removed – so that ‘you are *not allowed* to give suboptimal treatment’ (both reference 134). The LMDS and subsequent SINAP audit and data returns ensured that each HASU reproduced the agreed standards or risked losing accreditation and funding. The link between performance and funding was crucial in establishing and maintaining the new importance of stroke for the respective organisations (reference 87) and was compatible with both professional and managerial logics (Darr et al, 2003). This control was enhanced through the clinical supervisory work of the Pan-London Stroke Clinical Advisory Group and the regional networks and close links with commissioners. This built on personal relationships (Dopson and Fitzgerald, 2005) fostered through peer review visits and the electronic panopticon of the SINAP data. The networks functioned as ‘learning systems’ (Davies and Nutley, 2000) through peer to peer comparison and pressure to demonstrate professional and organisational competence.

The clinical autonomy of professionals to treat stroke patients (relatively unsupervised) based on traditional, or tacit knowledge was subordinated to new regimes of government increasingly based on ‘encoded knowledge’ (Flynn, 2002). This process was led by senior stroke care professionals and presented by them as central to delivering the standardised care which was best for the patients across the whole city – ‘people should follow guidelines and be measured against it and get good at that’ (reference 78). In this way, variation became less

acceptable and more easily identifiable and open to challenge as a part of the new regime of government. Therefore the re-stratified (Freidson, 2001) control over professional decision making and actions was significantly increased. This highlighted the disciplinary elements (Foucault, 1977) of EBHC. The regimes of audit and guidelines were constructed by and closely identified with professional leaders who appeared to have internalised the discourse of managerialism (Joyce, 2001; Doolin, 2002; Ferlie et al, 2011). These new regimes of increased audit and guideline influenced care and subsequently were based on relevant evidence, and therefore, on the whole, clinically legitimate in the eyes of the staff tasked to implement them (Herk et al, 2001; Weisz et al, 2007) – in contrast to political targets, such as the four hour A and E waits (reference 146).

The requirement to continuously record evidence that care complied with the tariff mandated standards locked Trusts in to a disciplinary cycle of audit that reproduced the key goals and facets of the new episteme. In this way evidence *of* practice became a sophisticated management tool to increase control over professional behaviour, and where weaknesses were identified, it could then become evidence *for* practice (improvements). Informants at *Kenworthy* expressed how the disciplinary pressure of the new regimes of government and practice impacted upon on the subjectivities of staff (reference 133), and professional leaders emphasised their desire to reduce clinical autonomy and impose restrictions on clinical staff to deviate from the evidence based model they have designed (reference 134). In this way, the new regimes of government may be seen to function through powers of subjection (Timmermans and Angell, 2001; Armstrong, 2002; Broom et al, 2009; Dean, 2010).

Such an approach emphasised increased hierarchical professional relations, further surveillance of professionals and augmented regimes of calculability and accountability (Timmons, 2003; Waring, 2007) suggesting that EBHC may be interpreted as a form of disciplinary power (Foucault, 1977) which imposes systems of measurement on individuals (Brown and Lewis, 2011). It is clear that this disciplinary power exerted increased pressure on stroke specialist staff at *Kenworthy* as they faced greater scrutiny of their actions from both peers and senior (clinical and managerial) staff both within the hospital and across the relevant network (reference 118, 122). Protocolisation of specialist stroke practices potentially pressurised staff to reform their behaviour and modify their actions and improve performance as they became vastly more accountable for this through the strictures of the SINAP audit.

However, the ways in which such pressure was felt was variable. At *Kenworthy*, the nursing staff were put under increased pressure and greater scrutiny to perform by senior medical and nursing managers (e.g. the matron and stroke consultants) as highlighted by references 117 and 118. This was pressure from fellow professionals rather than non-clinical general management and therefore counter to the findings of Timmons (2003) better aligned with the nurses' professional identities and ethical desires. A discourse of self-improvement was internalised by senior nurses such as the ward manager and the HASU coordinator (references 126, 129 and 131) who emphasised a commitment to using this disciplinary power *productively* (Foucault, 1991; Brown and Lewis, 2011) – to drive up standards. The position of nursing at *Kenworthy* must be understood within the historical context of 'failure' expressed by informants at the site. These data are consistent with the concept of managerial hegemony (Waring and Currie, 2009) in which professionals internalise managerial imperatives.

Likewise, the disciplinary power of the new episteme and restrictive targets impacted heavily upon the Clinical Services Manager who claimed she would ‘*die of shame if we failed an assessment*’ (reference 123). However she was in favour of such pressure being used as a productive force (notwithstanding the tears of her therapists!) because she saw such surveillant power as ultimately positive to ensure that standards were met (reference 124). Junior doctors also faced increased pressure from seniors as the stakes behind rapidity of treatment delivery were substantially raised (Timmermans and Angell, 2001; Broom et al, 2009). This accent on the disciplinary aspects of EBHC emphasised standardisation (Timmermans and Berg, 2003) and compulsion over enactment (Dopson and Fitzgerald, 2005) and local innovation. Conversely, the disciplinary power (Foucault, 1977) of EBHC in the London stroke case fostered an interpretive space (Iedema and Rhodes, 2010) in which leaders and fellow team members were able to realise their desires (Foucault, 1986; McKinlay and Starkey, 1998) as *stroke specialist professionals* and enact evidence based stroke care (Davies and Nutley, 2000; Dopson and Fitzgerald, 2005).

Therefore some informants emphasised the ability which providers had to elaborate and innovate within the broad rules set down by the new episteme: ‘how we did it, how we organised it, what it looked like, was entirely something we could create’ (reference 148) to effectively ‘enact’ the guidelines and shape them to their local contexts (Dopson and Fitzgerald, 2005). These stroke specialists’ revelled in the new episteme which despite its disciplinary tenets was a ‘productive’ force (Brown and Lewis, 2011) for them. These stroke specialist staff at *Kenworthy* internalised and utilised the positive potential of the disciplinary elements of the new episteme of stroke care in the London model in order to achieve their

professional desires (Foucault, 1986; McKinlay and Starkey, 1998). This view emphasises subjectification over subjection (McKinlay and Starkey, 1998) for these staff.

Paradoxically, the *reduction* of space for action which the new regimes of practice foster in the HASU when viewed from the perspective of an ever restrictive, controlling episteme was actually welcomed by staff and interpreted as an *opening up* of space because for the first time, there was a coherent, shared conception of stroke which legitimated increased jurisdictional space for stroke care specialists within the institution, and the city more broadly (Flynn, 2002; Doolin, 2002). This seemingly ‘restricted’ or ‘controlled’ space was desirable for stroke specialists because it was a space which enabled them to exert their situated agency (Bevir, 2010) both individually and collectively more effectively and challenge the previously dominant Discourse which saw stroke as subordinate to multiple other clinical specialities. In this way professionals can be seen to ‘problematise’ themselves in relation to dominant and countervailing forms of power (Foucault, 1986; Haugaard, 2002, p186).

So, through subjectification to new regimes of discipline, realisation of desire was possible (Foucault, 1986; McKinlay and Starkey, 1998) for these staff. By actively acquiescing to the data return requirements of LMDS and SINAP which opened the unit up to a performative external gaze of networks, commissioners and the RCP, stroke specialist clinicians and managers were able to harness this disciplinary power productively. In this sense, surveillance was crucial – it was the ‘*central ring holding it all together, that enables people to become powerful in their own fiefdom. Whereas, if they can’t report back... who’s going to take any notice of them?*’ (reference 82) The stroke service management at *Kenworthy* were able to turn the disciplinary power back on to non-stroke specialist management within her

Trust. This stroke service manager could ‘use the networks as a bogey man’ (reference 140) to protect her nursing establishment.

By colonising (Power, 1999) the performance metrics of stroke care in the city, stroke consultants were able to reconfigure the *managerial* markers by which non-clinical managers were to be judged (references 77 and 79). In these ways, disciplinary power furthered the jurisdictional cause of this group and demarcated stroke specialist care. This demonstrated a shared stroke specialist professional and managerial instance of ‘reverse managerialisation’ (Waring and Currie, 2009) built around the particular jurisdictional interests of stroke care. The new distinctions in identity terms delivered by the new regime of practice (Dean, 2010) here were between stroke specialists and non-stroke specialists (both professionals *and* managers), rather than between professionals and managers – which once more illustrates the unifying potential of the new stroke specialist episteme. The following section explores how this may have been achieved; through an exploration of the ways in which these developments impacted upon individual and collective identities.

‘Subjectifying logics’

The previous section highlighted that central tenets and techniques of EBHC – regimes of measurement, standardisation and protocolisation of professional practice for example can be seen as manifestations of disciplinary power – and that this power may represent a productive force. Discipline acts upon identity formation (Burchell, 1991; p146; Rose, 1999; p244) and is linked to what Foucault terms ‘techniques of the self’ defined as ‘those intentional and voluntary actions by which men [sic] not only set themselves rules of conduct, but also seek

to transform themselves, to change themselves in their singular being and to make an *oeuvre* that carries certain aesthetic values and meets certain stylistic criteria' (Foucault, 1986 p10).

This section explores the idea that key figures involved at the pan-London level as well as at *Kenworthy* – cultivated and were encouraged to cultivate stroke specialist identities.

Furthermore, these identities were symbolically imbued with 'evidence based' principles – to guide them to practice health care in 'instinctively' evidence based ways (Dopson and Fitzgerald, 2005). It was this that enabled them to draw upon the disciplinary regimes of government (Dean, 2010) which sought to control clinical responses and decision making prioritised by the reconfiguration to mandate a socially mediated 'subjectifying logic' (Martin et al, 2013) to legitimate the disciplinary nature of the new episteme at the local level.

EBHC manifests a dual clinical and managerial rationality which emphasises the ethical imperative to provide 'best' care (in the interests of both individual patients and epidemiologically defined groups) whilst also furthering the functional management goals of productivity and efficiency (Southon, 1994; Ten Have, 2000; Flynn, 2002). Thus, the 'enrolment' of professionals into a management discourse may be interpreted as an effect of neoliberal ideology permeating the medical profession - aligning clinical and administrative decisions (Osborne, 1993; p353).

However, the professionals studied in this thesis were not passive, docile recipients of management agendas, but active, ambitious agents reflexively aware of the utility of the employment of managerialism in the furtherance of their professional jurisdiction (Abbott, 1988; Armstrong, 2002; Doolin, 2002; Timmermans and Berg, 2003; Ferlie et al, 2011). Theories of hybridisation have indeed 'blurred the boundaries' between managerial and

professional identities (Dent, 2003; Numerato et al, 2011). There were two principal types of hybrid managers identified in these data. Firstly; medical-manager hybrids and secondly; nurse/AHP-manager hybrids. The ‘hybrid’ medical-managers were not reluctant or hostile to the force of managerialism – they did not see it as a force encroaching on their terrain – rather they welcomed and internalised (Waring and Currie, 2009) it as a power resource to further their jurisdictional goals. These senior ‘clinical leads’ (stroke specialist consultants) for HASUs and SUs in the capital maintained their clinical credibility by continuing to practice as doctors, whilst maintaining an academic profile through research collaborations and political influence via affiliation with the RCP and other professional bodies. In this sense, these doctors represented ‘strategic’ clinical managerial hybrids (McGivern et al, 2006). They displayed both managerial authority and clinical credibility, the latter of which was heavily underscored by an ethically motivated logic of EBHC focused on the pursuance of a quality health care system as a collective good (Numerato et al, 2011).

The second group of hybrid managers were employed principally by the networks and within the management structure at *Kenworthy* and included Network Directors, Clinical Service Managers, Ward Managers, and the Care of the Elderly and Stroke Director at *Kenworthy*. These individuals all had either nursing or AHP backgrounds and some had subsequently ceased to practice or had reduced their clinical commitments as respective professionals in order to perform full-time management roles. They also drew on the ethical dimension to the discourse of EBHC in accounting for their motivation for increasing control over stroke professionals, though were less likely to emphasise their mastery of the latest research than were the medical hybrids.

Alongside the ‘hybrids’ were non-clinical general managers – particularly those in senior positions within the SHA and PCTs. Whilst by definition not clinically trained, or credible in the interpretation of clinical data (and generalists rather than specialists), these managers were comfortable drawing on the discourse of EBHC and recognised its utility in depoliticising contentious decisions – and even presenting non-evidence based decisions as such – much to the ire of certain professionals as demonstrated in relation to the site selection controversy covered in chapter VI.

The significance of this is that at both the pan-London level and also at *Kenworthy*, the discourse of EBHC was powerful for senior professionals (medical hybrids, and nursing/AHP hybrids) and (general) managers because it enabled them to simultaneously speak both the language of *management and of professionalism* highlighting the mutually compatible goals of both communities (Numerato et al, 2011). EBHC as a Discourse for professionals and managers was strongly aligned with the values of patient care, safety and professional pride (reference 129 and 132). These concerns justified the regular instigation of MDT meetings at *Kenworthy* (for example, a monthly meeting reviewed all thrombolysis cases) which reviewed performance and reflected on professional abilities to deliver effective care at the micro-level. Whilst at the meso-level for example, the observational data from the Pan-London Stroke Clinical Advisory Group emphasised the subjectifying logic (Martin et al, 2013) of professional leadership and discursive practice based on regular reviews of shared narratives around the efficacy of patient journeys through the system and potential problems with transparency and patient safety.

In this way the data suggested that those in leadership posts were particularly important because they were uniquely positioned to influence the construction of local contexts (Grint, 2005; Fairhurst, 2009) to be receptive to evidence based stroke care – thereby minimising dissent and professional opposition to the new (increasingly managerial) episteme. Local leaders interpreted broader Discourses by emphasising the utility of specific forms of practice over others thereby legitimating the disciplinary elements of the new episteme for junior staff (Timmermans and Angell, 2001; Broom et al, 2009) (see references 129 and 132). *Self-*discipline then became central to the new stroke specialist identities fostered by the reforms for staff (Dopson and Fitzgerald, 2005) on the new HASU and SU at *Kenworthy* (see references 126 and 132).

This self-disciplined cultivation of a specialist identity, as stroke specialist doctors, nurses, and AHPs working within the new regime of practice was significant in accounting for why these professionals welcomed the disciplinary regimes of the reformed London stroke care model and submitted themselves so willingly to techniques of management which may appear to have been rather restrictive. Evidence based health care has an ethical – or ‘inspirational’ (Ferlie et al, 2011) imperative. The HASU and SU staff at *Kenworthy* were able to draw on this imperative to demonstrate a collective transformation of themselves as high-functioning, responsible, caring and effective stroke specialist professionals. As demonstrated by Martin et al (2013), this was manifested communally drawing upon discursive reflective practice, led by credible clinical leaders, and justified by highlighting the patient benefits of transformed care. This validated submission to increased disciplinary regimes as an ethical realisation of desire (Foucault; 1986; McKinlay and Starkey, 1998) through the internalisation of managerialist logic (Osborne, 1993; Doolin, 2001; Pickard, 2009; Waring and Currie, 2009) for some staff whilst for others, the disciplinary power of the

new episteme functioned by minimising the potentialities and coherence of resistance (Newman, 2005).

8.5 Summary

This chapter offered a discussion of the main theoretical and empirical findings of the thesis. It presented these in three stages – firstly; the problematisation of stroke services in the capital which it was suggested led to a refashioning of the episteme of stroke care in London. Secondly, the development of the new episteme amongst professional, managerial and other stakeholders was explored. Finally, the techniques developed for the implementation of the new episteme were discussed in theoretical terms with reference to the empirical data collected at both the micro- and macro-levels. The important distinctions between evidence *of* and *for* practice were described. Following Dean’s analytics of government approach, a non-subjective intentionality (Dean, 2010) of the London stroke reconfiguration was offered which emphasised an increased factor of management control through a reified episteme of evidence based stroke care. Rather than being imposed upon professionals by managers, this was developed collaboratively between the two communities emphasising the compatibility of their goals.

A specifically ‘biopolitical’ approach to interpreting service reconfigurations was developed, with close links to the analysis of EBHC functioning as a ‘power/knowledge nexus’. The paradox of increased managerial control being experienced as professionally liberating for stroke specialist staff was explored which led to a further discussion around key Foucauldian concerns related to discipline, and disciplinary power alongside desire and governmentality

as an organising concept. The following chapter offers concluding thoughts on the empirical and theoretical significance of the thesis and also reflects upon its limitations and the potential for future research which may build on these findings.

Chapter IX

Conclusion

9.1 Introduction

This final chapter reflects back on the thesis as a whole and addresses four distinct areas. Firstly, the wider theoretical implications beyond the case are discussed. Secondly, the practical implications that these findings have for health policy more broadly are developed. Following this, some reflections on the research journey and limitations of the study are commented upon before the final section presents future avenues for potential research.

9.2 The theoretical implications of this research

An important theoretical contribution which this thesis makes to the health care management literature is to demonstrate the utility of interpreting service reconfiguration as a *biopolitical* intervention (Foucault, 2007). This is significant in two respects; firstly in relation to specifically Foucauldian influenced studies in health care – which do not fully exploit this potentially significant aspect of Foucault's work; and secondly in relation to health service research studies of reconfigurations – studies which are frequently underdeveloped in theoretical terms (Fulop et al, 2012).

It was noted that Foucauldian theory was under-utilised in the exploration of strategic level change and service reconfiguration. This thesis has attempted to address this gap in the

literature by demonstrating the theoretical utility of presenting specific service reconfiguration across a defined geographic area as a biopolitical (Foucault, 2007) intervention. Foucault's notions of 'case, risk, danger, crisis' (Foucault, 2007) identifying and legitimating direct and indirect governmental action are potentially theoretically useful beyond this specific case. This is because such an approach encourages analysis of *how* problems are identified at certain times in certain locations which is very much in line with Dean's analytics of government approach (2010) and stems from Foucault's method of 'problematization.' What is additive however, is that a biopolitical framing sensitises the analyst to a critical handling of the role of epidemiological knowledge (of specific populations) and how evidence is discursively used to promote or inhibit change as used by stakeholders involved in the political framing of health care redesign. This is often lacking in other reconfiguration studies.

Biopolitics encourages the development of, and is subsequently sustained by a power/knowledge nexus (Ferlie et al, 2011) consisting of individuals and institutions that derive their legitimacy from the creation and interpretation of detailed data about specific populations and phenomena, so an exploration of service redesign as a biopolitical intervention is theoretically useful in encouraging analysis of how specific power/knowledge nexuses develop and function. This enables the study of particular specific historical phenomena consistent with a commitment to the 'singularity of ways of governing and conducting ourselves' (Dean, 2010; p30) at the heart of the analytics of government approach. However, this does not mean that theoretical generalisation is impossible, and a therefore a number of theoretical implications for the study of health service reconfiguration beyond the present case are offered.

A biopolitical theory of reconfiguration is concerned with a critical questioning of the legitimacy of not only the evidence behind the service redesign itself – but just as importantly, how discourse is developed around this evidence and how this then impacts upon ethical and economic perceptions of the key reforms through the long process of reconfiguration. Therefore it is important to make the distinction between evidence *for* practice, and evidence *of* practice. These two forms of knowledge are closely related but perform separate functions. Evidence *for* practice is used to reify a specific problem – rendering it ‘knowable’ in a new way and in so doing legitimate a new episteme. The increasing influence of evidence based health care on policy making in London since the 1990s discerned be traced through analysis of policy documents (as in chapter V section 1) demonstrating how the new discourse comes to de-politicise contentious decisions by showing how change may positively impact upon defined populations.

A biopolitical theory of reconfiguration is also concerned with the population(s) affected by the reconfiguration – this refers to the public of a specific locale, a sub-group who as patients will be affected more heavily than others; also the professionals whose work is altered; and finally, those tasked with managing the governance of the new arrangements. Evidence *of* practice functions by assuring the delivery of the proposed benefits through increased targeted surveillance with impacts for governance arrangements and staff subjectivities. The London stroke reforms drew upon a discourse which emphasised clinical leadership and strategic management collaboration – this was an important factor in de-politicising elements of service redesign. Despite this de-politicising potential, EBHC is nevertheless a phenomenon with *political* implications – and this is clear to professional, managerial and other stakeholders. Indeed, a further contribution this thesis makes is to explore managers’ roles and their reflexivity in interpreting and using the politically powerful Discourse of

EBHC and professionals' understanding of this – both when the goals *are* and *are not* compatible between the two groups. It is suggested that evidence is negotiated and mediated amongst elite groups to further specific ends at specific times and that this is well understood by the respective parties.

Building on these ideas, the thesis also makes a number of further contributions to theoretical debates related to the Foucauldian literature on governmentality in health care. An important one is the development of a specific London stroke 'power/knowledge nexus' (Ceci, 2004; Shaw and Greenhalgh, 2008; Ferlie et al, 2011; Ferlie and McGivern, 2013) as part of the reconfiguration and how this impacts upon the creation, interpretation and validation of numerous 'evidence based' strategies to reform and improve the regimes of practice for stroke patients. The power/knowledge nexus concept is explored empirically demonstrating the importance of management consultancy and public relations skills alongside the legitimising acquiescence of professional patient/carer groups and the marginalised nature of the public consultation in shaping change. It is shown how professional jurisdictions may be extended (academic clinical elites) or curtailed (AHPs) through the functioning of a power/knowledge nexus in a specific disease type in a specific location.

A further important theoretical contribution this thesis makes to the Foucauldian literature on governmentality in health care relates to an interpretation of the 'non-subjective intentionality' (Dean, 2010) of the London stroke reconfiguration programme. It is suggested that increasing management control over professional processes focused on caring for stroke patients was central to this 'non-subjective intentionality.' The reforms heralded increased surveillance over the regimes of practice relating to the care of stroke patients. This surveillance functioned not merely as a disciplinary force, but was utilised *productively* by

both management and professional communities; in theoretical terms, the thesis demonstrated how EBHC may be seen to function as a disciplinary force with productive power (Foucault, 1977; Brown and Lewis, 2009; Iedema and Rhodes, 2010) aligning the somewhat contradictory calls for ‘standardisation’ of care (Timmermans and Berg, 2003) and local ‘enactment’ (Ferlie and Dopson, 2005) of evidence based care. This highlights the complexity of the new regimes of government and practice (Dean, 2010) fostered by EBHC.

These new regimes of government (Dean, 2010) appeal to both ‘economic’ and ‘ethical’ logics and may be experienced by staff as both forms of *subjection* and as forms of *subjectification* (Dean, 2010). In this way, the thesis contributes to the theoretical debate around the interplay between discipline and governmentality (Martin et al, 2013) and how multiple and conflicting tactics of governance (Newman, 2001) may be drawn upon simultaneously highlighting the complexity of health care management. These two competing conceptualisations of Foucauldian power are rarely both accounted for together in health care studies (Martin et al, 2013) – this thesis adds to the previous work which explores how they may be seen to coexist.

Rather than leading to professional resistance as might have been expected, the increased management control identified as part of the London stroke reforms was welcomed and indeed pursued by both senior and junior professionals – highlighting that professionals and managers share more complex relationships than is often highlighted in the literature (Numerato et al, 2011). An important contribution this thesis makes is to demonstrate *how* this alignment of management and professional goals was achieved. Central to this was that firstly, the new regimes of audit and measurement overall were based on relevant clinical

evidence and therefore seen as legitimate by most professionals. Secondly, the expressed ethos behind the new regimes of government was to ‘*performance manage Trusts*’ rather than individual clinicians – this functioned in the mutual interest of both SHA and PCT managers and stroke specialist service managers and professionals at the hospital level and was overseen by a trusted, respected intermediary body in the shape of the networks. This crucially important alignment of (professional and management) goals legitimated a reduction of clinical autonomy for front line stroke specialist staff whilst simultaneously furthering the same professionals’ desires to realise their own ethical needs and clinical goals (McKinlay and Starkey, 1998). Thus a reduction in clinical autonomy through increased discipline is experienced in productive terms for professionals.

9.3 The practical implications of this research for health policy

There are a number of important practical implications raised by this thesis. The first of these relates to the need for, or desirability of, regional level strategic health focused organisations. One of Andrew Lansley’s key acts as Health Secretary was to abolish SHAs along with PCTs as I was half way through writing this thesis. Nigel Edwards famously joked that the only things guaranteed to survive nuclear war would be ‘cockroaches and regional health authorities’ (Timmins, 2012) and therefore following this argument, it is likely that *some kind* of strategic/regional health authorities will remain – whether under the rubric of the National Commissioning Board or elsewhere. Likewise Lansley’s ‘creative destruction’ of NHS institutional arrangements also led to a downscaling of regional clinical networks. In practical terms, the data collected for this thesis suggest that both the SHA and the networks functioned very effectively with respect to the stroke care reconfiguration.

Strong central strategic level leadership shared between managers and professionals appears to have been important to challenging the vested interests of institutionally powerful hospitals and may be effective in delivering coherent integrated acute and emergency level care (Morris et al, 2014). However, whilst reflecting on the achievements of NHS London with respect to emergency care reforms, it must not be overlooked that other elements of care which Darzi and NHS London attempted to reform were apparently less successfully tackled – in stroke, prevention and rehabilitation appear to have been marginalised to the needs of the acute care reforms, and another example away from stroke might be the failure of polyclinics to be rolled out as extensively as Darzi’s vision called for (Appleby et al, 2011).

Focusing on (disease specific) services to be reconfigured (such as stroke and trauma in London); as opposed to individual hospital up/down-grading may be a practical way to defuse the inevitable fear that the public has when service redesigns are discussed. Clearly linked to this is the use of a Discourse emphasising the evidence behind specific clinical service reconfigurations and the ‘biopolitical’ aspect through which change can deliver improved rather than diminished services for patients and the public more widely. In public relations terms, service redesign is more likely to be palatable if the benefits for service users are well defined and publicised. Clearly, the fact that the stroke service reconfiguration in London was additive in financial terms was important, and ring-fencing funds for specific services may be an important way assuage public fears around service delivery change.

The compatibility of managerial and professional goals in the London stroke reforms is highlighted in the thesis. Where goals are shared and relationships are positive and consensual, large scale change stands a better chance of success than where there is discord.

Whilst this thesis has explicitly focused on the discursive role of evidence in influencing the London stroke reforms it has also identified a number of ‘non-Foucauldian’ themes that might explain certain elements of the reconfiguration process such as political bargaining and structural conflict between different communities (Alford, 1975); interprofessional jurisdictional conflict or profession building (Abbott, 1988; Freidson, 2001; Pickard, 2010). In this way, evidence is one of many factors which influence strategic health care change. Nevertheless, the thesis has endeavoured to highlight the discursive role played by evidence in structural conflict and the reification of stroke as a specialist discipline - drawing specifically upon the legitimating power of new evidence based advances in stroke care (Langhorne and Dennis, 1998). It might be speculated that less well established disciplines (such as stroke) might be more willing to submit to increased regimes of audit and managerial control than more established, historically well established and structurally dominant disciplines (for example, surgery – as highlighted by Waring (2007) in his patient safety study). A practical implication of this research might be that large scale service redesign which requires increased managerial input and oversight may be less contentious if focused on emergent specialities with new evidence bases.

This thesis offers some thoughts on the effectiveness of late New Labour health policy making. Increased audit and targeted tariff arrangements did incentivise both professional and managerial stakeholders to alter their practice. Clinical leadership was more than a mere rhetorical construct in these particular reforms, and commissioners were closely involved in ensuring that historic underperformance in stroke care was challenged aided by responsive networks. The data from the micro-level study suggests that at the same time, this did increase pressure on staff and the disciplinary power of increased regimes of surveillance led

to some disaffection – particularly for lower status staff. Thus increased regimes of audit must take into account the potentially negative effects they may have on staff – it was not always clear that this was factored into these reforms, and whilst MDT working was encouraged and became an important aspect of the new stroke regimes of practice, there also are some senses in which divisions between professional groups were exacerbated by the increased pressure of the new regimes of government.

These findings demonstrate that various programmes of reform may take a long time to influence regimes of government and ultimately practice – they build incrementally and show how government is a ‘constantly problematising activity’ (Dean, 2010). The change described here is contextually specific and dependent upon local and historical trends. The London reforms were informed by evidence *and* influenced by intuition – indeed, those who designed the London model highlight in interviews for this thesis, the lack of evidence for many aspects of it. Reforms – particularly high profile (and ‘successful’) ones like this may develop a perceived sense of ‘naturalness’ or ‘inevitability’ – it is important to challenge the ‘taken-for-granted’ nature (Dean, 2010) of such reforms – for two reasons: first – this type of reform constructs its own ‘scientific’ legitimacy and definitive episteme – but things could have been done differently and this should be highlighted; second - the London model has come to be cited so frequently in contemporary politics and referred to as a model of reference for further reforms across the country. As public opinion continues to regard the London stroke reforms in positive terms (Boseley, 2014), it is important that the London model is not seen as the *only* way to modernise the delivery of stroke care (or indeed other diseases). What is important is that the best aspects are consolidated in new services elsewhere, whilst the weaker aspects are recognised and improved as stroke care is reformed across England and beyond.

9.4 Reflections and limitations

This thesis generated many thousands of words from multiple sources for analysis. Given the volume of data, sometimes difficult decisions need to be made around the best ways to focus the study in both theoretical and empirical terms. A potential limitation of the present study may be that it focuses too heavily on the acute care aspects of the reconfiguration – to the detriment of the preventative and rehabilitation aspects of stroke care. Another criticism might be that an interest in the role played by clinical evidence was prioritised over other forms of evidence – commissioning, or finance evidence for instance. Both criticisms would be valid but may also be mitigated. Firstly, the data generated and analysed as part of the thesis is much richer with respect to acute care elements of the reconfiguration – it therefore made sense to explore this data as deeply as possible whilst drawing attention to how prevention and rehabilitation aspects were marginalised in both the design and implementation of the London model. Secondly, in justification of the clinical evidence prioritisation over other forms; again, there is more data on clinical evidence (in both volume and detail) than managerial, organisational, economic or financial evidence in the data collected by interview, documents and observations. Furthermore, my analysis of this data highlights that clinical evidence was more significant than other forms of evidence.

A further limitation is the lack of patient and public involvement (PPI) in this research. In some ways, this may reflect changing social science practice between the commencement of this PhD research in 2009 and its completion in 2014. Were it that I was starting this research now, I would approach a stroke survivor group at the outset to canvass opinion on potential

PPI factors to consider as part of the research – however this was less of a concern in 2009 than it may be seen to be now. The research is limited by the lack of PPI involvement and this was compounded by the difficulties faced in recruiting members of the patient representative panel to consent to be interviewed. Nevertheless, as important as the PPI angle is, the focus of this thesis and the research questions driving it is very much around *professional-managerial relations* and the ways in which these central stakeholder groups interpret, utilise and implement evidence in stroke care.

Another possible limitation was that the retrospective nature of the research hindered ‘real time’ observations of the work of the various panels involved in the early work of the reconfiguration. Likewise the time in the field at *Kenworthy* was restricted which also hindered attempts to generate micro-level observational data which might have strengthened the overall dataset. Taken together, this inability to apply a longitudinal timeframe to certain (but not all) aspects of the research made data collection focused on the *identity* strand of the analytics of government difficult. A limitation of the embedded case study design at *Kenworthy* was that the thesis only studied one hospital site – and it was one which benefitted from the reconfiguration by virtue of the increased funding, staff and overall profile that came with HASU, SU and TIA service investment. Given greater resources, it might have been useful to have also researched staff perceptions at the micro-level at a unit that did not benefit in the same way from the site selection – staff perceptions at sites which ‘lost out’ may well be very different from those that might be termed ‘HASU winners’. However, whilst recognising this limitation, firstly, given the inevitable limits of PhD research there is justification that if only one site may be explored in detail, that it is one which was upgraded by the reconfiguration because it is here that the new model and its effects on staff can be best discerned. Secondly, the case study I interview data covered a number of staff who saw

their services downgraded and thus covers many of the issues felt and emotions generated for those working at ‘HASU loser’ sites. Thirdly, I was conscious that another research team with greater resources was conducting research comparing the experiences of HASU ‘winners and losers’ in London (and other cities) – so my findings will sit alongside this other research when published.

A final reflection focuses on the processes of anonymisation and pseudonymisation. Whilst the high profile nature of the London reforms is a positive factor which adds to the interest and wider relevance of this work, it also has to be noted that the London stroke ‘world’ is relatively small and many of the individuals are well known to the London NHS community – likewise there were relatively few senior SHA managers involved in the reconfiguration and the names of both clinical and managerial stakeholders are published and available via NHS London documents and webpages. Likewise, with reference to the site selection issue, there is plenty of data in the public domain relating to how different hospitals were affected – limiting the strength of my use of pseudonyms. Added to this are my personal and professional relationships with some of the key informants that have developed over the years through both the PhD and the EIS project, complicating my ethical commitments to stakeholders and perhaps leading to (self) censorship of certain aspects of the interview data – as I feared that some comments – even anonymised – might be (rightly or wrongly) attributed to certain figures and that this might be problematic. Some data has therefore not been used for these reasons.

9.5 Future research agenda

This research has suggested that Foucault's concept of 'biopolitics' (2007) is potentially useful to frame studies of health care reconfigurations. It would be interesting to develop this theory by applying it to other health care reconfigurations to test it further – what for instance could such a concept teach us about other attempts at reconfiguration? As an example, why have efforts to reconfigure paediatric cardiology services proven so difficult? In biopolitical terms, it might be interesting to consider the type of population for who services are being reconfigured; it might also be fruitful to consider the impacts that the geographical areas covered by reconfiguration has on efforts at reform.

Another potentially fruitful avenue would be to consider further research into manager-professional relationships in reconfigurations. This thesis has found a high degree of compatibility between the two traditionally dominant powers – is this related to the jurisdictional work around 'professionalising' stroke as a distinct subspecialty – might change focused on established specialisms be more fraught in relational terms? Likewise, would change in more financially restricted times be more difficult than that of the stroke reconfiguration in London?

It might be interesting to focus research into the identities of senior professional leaders as they take on more managerial responsibilities as part of drives for clinical leadership led by service reconfigurations. Also work may be needed on the furtherance of prevention, rehabilitation and community developments in stroke – for example around ESD services. Likewise, further work is required to explore how the roles previously overseen by SHAs and PCTs are performed in the 'new' NHS (if at all). Finally, more work on the power/knowledge

nexus concept and how it creates, implements and assures compliance to evidence based guidelines and practices, and the impact this has on both professional and managerial subjectivities would be very welcome.

Chapter X

References and Appendices

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Appendices

Appendix A: Timeline of London Health Care Reform and stroke developments

| London Health Service reform (taken from Appleby et al, 2011 p2) | Year | Developments in stroke care (taken from unpublished EIS working paper [Rudd] and Langhorne and Dennis, 2008) |
|--|------|--|
| Select Committee of the House of Lords' report on metropolitan hospitals | 1890 | |
| Report of the Interdepartmental Committee on Medical Schools (Goodenough) | 1944 | |
| Hospital Survey of Greater London (Clark et al) | 1956 | Early experimentation with 'proto-SUs' (e.g. Northern Ireland) |
| Towards a Balance (London Health Planning Consortium (LHPC)) | 1979 | Norwegian and Swedish SUs established |
| Primary Healthcare for inner London (LHPC) | 1981 | |
| | 1983 | Nottingham Hospital SU established |
| Planned Health Services for Inner London: Back to Back Planning (The King's Fund) | 1987 | |
| London Healthcare 2010 (The King's Fund) Tomlinson Report: Inquiry into London's Health Service, Medical Education and Research | 1992 | |
| Making London Better. Government Response to Tomlinson | 1993 | |
| | 1995 | Research - NINDS trial (thrombolysis trial up to 3 hours) |
| London Commission: Transforming health in London (The King's Fund) Turnberg Report: Health Services in London: a Strategic Review (Department of Health) | 1997 | Research - Stroke Unit Trialists' Collaboration |
| | 1998 | Audit - National Sentinel Audit |
| | 1999 | Audit - National Sentinel Audit Changes to training/status of stroke professionals - British Association of Stroke Physicians established (the first stroke medical organisation in the UK) |

| | | |
|---|------|--|
| | 2000 | Guidelines - RCP National Clinical Guidelines 1 st edition Audit - National Sentinel Audit |
| | 2001 | National Policy Documents - National Service Framework for Older People set 'milestone' that every hospital in England should have a stroke unit by April 2004 and also some other milestones on TIA management |
| | 2002 | Audit - National Sentinel Audit |
| | 2004 | Guidelines - RCP National Clinical Guidelines 2 nd edition Audit - National Sentinel Audit Targets and funding – QOF targets for stroke |
| | 2005 | Audit – National Audit Office – <i>Reducing Brain Damage: Faster access to better stroke care</i> |
| | 2006 | Audit - National Sentinel Audit Development of networks of professionals -UK Stroke Forum established. Largest multidisciplinary stroke meeting in the world with >1500 attendees at the annual meetings |
| Darzi Review: Healthcare for London – A Framework for Action (Healthcare for London) | 2007 | Research - EXPRESS study (Rothwell et al) showing that rapid intervention after TIA highly effective at preventing stroke Guidelines - NICE Technology Appraisal on tPA – should be provided to all appropriate National Policy Documents – National Stroke Strategy (DoH) Changes to training/status of stroke professionals - Stroke established as a |

| | | |
|--|------|---|
| | | medical specialty in UK. Steady increase in training posts since then and a big expansion in the number of stroke consultant posts in the UK. |
| | 2008 | <p>Guidelines - RCP National Clinical Guidelines 3rd edition</p> <p>Guidelines - NICE Guidelines on Acute Stroke and TIA</p> <p>Audit - National Sentinel Audit</p> <p>Targets and funding – Vital Signs – 90% stay on stroke unit and proportion patients with high risk TIA seen and treated within 24 hours</p> |
| | 2010 | <p>Research - CLOTS trials showing that stockings ineffective preventing DVT after stroke</p> <p>Guidelines - NICE TA on anti-platelet agents recommending the combined use of aspirin and dipyridamole for secondary prevention updated to recommend clopidogrel</p> <p>Audit - National Sentinel Audit</p> |

Appendix B: London Minimum Data Set

Minimum data set

| Metric Ref | Indicator | Metric | Operational Definition |
|------------|-----------------------------------|---|---|
| 1 | Preventable Strokes | Proportion of patients presenting with stroke with AF anti-coagulated on discharge (60% by April 2011) | <p>This measure refers to secondary prevention.</p> <p>Proportion of patients presenting with new stroke with atrial fibrillation who are discharged on anticoagulation.</p> <p>Denominator- number of patients admitted with a stroke also with atrial fibrillation (newly diagnosed on this admission or previously diagnosed)</p> <p>Numerator- the number of these patients who were discharged on anticoagulation or who had a plan for anticoagulation to start, when clinically appropriate, in the discharge letter or medical notes.</p> <p>Record the number of patients admitted with confirmed stroke with atrial fibrillation.</p> <p>Record the number of patients who are discharged on anticoagulation and the number who have a plan for anticoagulation to start in the next month in the discharge letter.</p> <p>Tolerance- The metric has already taken into account the proportion likely to be excluded ie patients in whom anticoagulation is contraindicated or who decline.</p> <p>Anticoagulation refers to treatment with an anticoagulant such as Warfarin and not an antiplatelet such as Aspirin or Clopidogrel.</p> |
| 2 | Direct admission to a stroke ward | Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival (90% by April 2011) | <p>Denominator- number of patients with confirmed stroke in an acute stroke unit bed at 4 hours after arrival at hospital.</p> <p>Numerator- number of patients with confirmed stroke in an acute stroke unit bed at 4 hours after arrival at hospital.</p> <p>For each patient with confirmed stroke record date and time patient arrived in hospital and date and time patient arrived in a designated stroke bed.</p> <p>Directly - in this context means that the patient goes straight to the acute stroke unit without spending time on another ward including assessment units. The metric allows for up to four hours to be spent in the Emergency Room/Accident and Emergency or in the imaging department en route to the stroke unit.</p> <p>Tolerance- The 10% tolerance allows for patients in whom stroke diagnosis is delayed due to atypical presentation, those who are FAST and ROSIER negative, and those patients appropriately directly admitted to ITU/CCU/tertiary centre.</p> <p>Exceptions- Exclude from the denominator patients who have a stroke whilst in hospital.</p> |
| 3 | Acute stroke care | Proportion of patients spending 90% of their stay on a stroke ward (80% by April 2011) | <p>Definition and guidance as the DH VSMR guidance</p> <p>Other guidance as DH FAQs</p> |

| Rationale | Quality Marker | Pathway Stage | Data Source |
|--|----------------|---------------|---------------------------|
| <p>Atrial fibrillation is an important risk factor for stroke and is associated with about 15% of all strokes.</p> <ul style="list-style-type: none"> • Optimal treatment of AF in the population could reduce overall stroke risk by 10% • Anticoagulation is highly effective in reducing stroke risk in patients with AF by approximately 70% <p>The RCP national Sentinel Audit 2008 demonstrated that only 24% of patients with atrial fibrillation (AF) were discharged on warfarin and only a further 9% of people were planned to receive it in the future. Thus only a third of people with AF were likely to be anticoagulated. There are some good reasons not to anticoagulate (high risk of falls, severe stroke, likely difficulties with compliance etc) but it would not be expected to account for more than about a third of the stroke population at most. Warfarin is twice as effective as aspirin at preventing further stroke in people with AF. The rate of use has to be increased.</p> | 2 | Prevention | Acute Trusts / New data |
| <p>Timely access to acute stroke units prevents death and increases independence. National Stroke Strategy.</p> | 9 | Acute | SINAP |
| <p>Reported as a DH Vital sign</p> | 9 | Acute | DH Vital Sign data, SINAP |

| Metric Ref | Indicator | Metric | Operational Definition |
|------------|---|---|--|
| 4 | Access to brain imaging | <p>i) Proportion of stroke patients scanned within one hour of hospital arrival (50% by April 2011)</p> <p>ii) Proportion of stroke patients scanned within 24 hours of hospital arrival (100% by April 2011)</p> | <p>Needs to be collected as two metrics: one for patients who require immediate imaging (i) and one for patients who do not (ii).</p> <p>i) Proportion of patients scanned within one hour of hospital arrival</p> <p>Numerator - Number of patients admitted with acute stroke</p> <p>Denominator - Number of these patients who are imaged within one hour of hospital arrival (see criteria for urgent imaging).</p> <p>ii) Proportion of patients scanned within 24 hours of hospital arrival</p> <p>Numerator - Number of patients admitted with acute stroke as i) above.</p> <p>Denominator - Number of these patients imaged within 24 hours of arrival (this number will include those scanned within one hour).</p> <p>Record number of patients admitted with stroke. Record the date and time of admission. Record date and time of first brain imaging.</p> <p>Exceptions- Exclude patients not scanned or had a delayed scan for clinical reasons and patients who declined</p> <p>NICE recommendations for imaging</p> <p>i) Brain imaging should be performed immediately for people with acute stroke if any of the following apply:</p> <ul style="list-style-type: none"> • indications for thrombolysis or early anticoagulation treatment • on anticoagulant treatment • a known bleeding tendency • a depressed level of consciousness (Glasgow Coma Score below 13) • unexplained progressive or fluctuating symptoms • papilloedema, neck stiffness or fever • severe headache at onset of stroke symptoms <p>Immediately is defined as 'ideally the next slot and definitely within 1 hour, whichever is sooner'. In line with the National Stroke Strategy</p> <p>ii) For all people with acute stroke without indications for immediate brain imaging, scanning should be performed as soon as possible.</p> <p>'As soon as possible' is defined as 'within a maximum of 24 hours after onset of symptoms'.</p> |
| 5 | Management of high risk TIA | Proportion of high risk TIA patients investigated and treated within 24 hours of first contact with a health professional (60% by April 2011) | <p>Definition and guidance as the DH VSAIR guidance</p> <p>Other guidance as DH FAQs</p> |
| 6 | Timely access to psychological support | Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke (40 % by April 2011) | <p>Denominator - number of patients with stroke, alive at 6 months post stroke</p> <p>Numerator - number of patients who have been seen (assessed and/or treated) by service providing psychological support capable of managing mood, behaviour or cognitive disturbance by six months post stroke.</p> <p>Service providing psychological support for mood, behaviour or cognitive disturbance This service should be capable of assessing and managing individuals with mood, behaviour and cognitive disturbance and should comprise staff with specialist expertise and competence in assessing, treating and monitoring people with these needs eg clinical psychologist, psychiatrist, primary care mental health worker or be stroke specialists with additional expertise in managing people with these needs eg stroke specialist counsellor, stroke specialist practitioner eg occupational therapist</p> <p>Mood behaviour or cognitive disturbance might include anxiety, emotionalism, depression, denial and difficulty coping emotionally and psychologically with the stroke which impedes recovery, problems with orientation and memory and inappropriate behaviour.</p> <p>Exceptions: Exclude patients who have died, patients who decline the assessment/intervention</p> <p>Tolerance- 40% reflects evidence of likely numbers of individuals post stroke who could be expected to have problems with mood behaviour and cognition</p> |
| 7 | Joint health and social care management | Proportion of patients and carers with joint care plans on discharge from hospital (85% by April 2011) | <p>Denominator- number of stroke patients discharged alive</p> <p>Numerator - number of these patients (or their carers) who have a copy of their joint care plan on discharge from hospital</p> <p>Joint care plan- documented evidence of an assessment and management plan which takes into account the patients and carers health and social care needs. The content of the care plan should be jointly decided by both health and social care staff</p> <p>Exceptions: Exclude patients who have no documented health or social care needs, patients not resident in the UK and patients who refuse a health/social care assessment or intervention.</p> <p>Tolerance- allowance has been made for individuals for whom it would not be appropriate to share sensitive information and those for whom the information would be inappropriate.</p> |

| Rationale | Quality Marker | Pathway Stage | Data Source |
|---|----------------|-----------------------------------|--|
| Brain imaging should be performed immediately for defined groups of people with acute stroke. For people without indications for immediate imaging, scanning should be performed as soon as possible (within a maximum of 24 hours after onset of symptoms) RCP National Clinical Guidelines for Stroke, NICE Guideline for stroke and TIA and National Stroke Strategy | 8 | Acute | PACS Sentinel Audit, SINAP Best Practice Tariff |
| RCP National Sentinel Audit 2008 21% of patients, for whom both times are known, are scanned within 3 hours of stroke which is an improvement over the last audit but nowhere near high enough if patients are to achieve the best outcomes. The same comment applies to the figure of 65% scanned within 24 hours. | | | |
| | 5 and 6 | TIA | DH Vital sign data |
| People who have strokes access high quality rehabilitation. Targeted interventions can help specific problems. National Stroke Strategy. Patients receive the ... emotional support they need. Carers should be able to access the help and support they need RCP National Clinical Guidelines for Stroke. Evidence for depression, anxiety and poor cognition rates from the South London Stroke Register. | 10, 13 | Rehabilitation, Life after stroke | New data Could be collected at six week and six month review. |
| Everyone with a long term condition should be offered a care plan by 2010 (Our Health, Our Say) and all primary care trusts and local authorities will need to have established joint health-social care managed networks/teams to support this. National Stroke Strategy | 12 | Life after stroke | New Data |

| Metric Ref | Indicator | Metric | Operational Definition |
|------------|--|--|---|
| 8 | Assessment and review | Proportion of stroke patients that are reviewed six months after leaving hospital (95% by April 2011) | <p>Number of stroke patients reviewed at 6 months post hospital discharge</p> <p>Denominator- number of people with stroke discharged alive who are still alive at 6 months</p> <p>Numerator- number of stroke patients reviewed at 6 months post hospital discharge</p> <p>Review- should be a multifaceted assessment of need and should encompass the individuals:</p> <ul style="list-style-type: none"> -Medicines/General Health needs -Ongoing therapy and rehabilitation needs -Mood, memory cognitive and psychological status -Social care needs, carer wellbeing, finances and benefits, driving, travel and transport. <p>A review which included only stroke secondary prevention would not be considered to be acceptable. Reviews could be carried out in a primary care setting and could be carried out by social care, however the model of service delivery will need to be decided locally as long as the content of the review is a multifaceted assessment of need.</p> <p>Exceptions: Exclude patients who have died, patients who decline the review or patients who live out of the area. The review should be offered to all stroke survivors even those who may not appear to have residual impairment.</p> <p>Tolerance: It is acceptable for the six month review to take place between five and seven months post discharge</p> |
| 9 | Access to and availability of ESD services | <p>i) Presence of a stroke skilled Early Supported Discharge team</p> <p>ii) Proportion of patients supported by a stroke skilled Early Supported Discharge team (40% by April 2011)</p> | <p>Is there an Early Supported Discharge Service according to the guidance given below. This is reported as Yes/No.</p> <p>To answer Yes the service must have seen at least one patient for early supported discharge</p> <p>If No select from the following</p> <p>Intention to implement ESD services in next month</p> <p>Intention to implement ESD services in next 3 months</p> <p>Intention to implement ESD services in next 6 months</p> <p>No intention to implement ESD service</p> <p>Intention to implement requires business case and service specification in place and agreement for the service to be commissioned.</p> <p>Proportion of patients supported by an Early Supported Discharge team</p> <p>Denominator- number of stroke patients discharged alive</p> <p>Numerator- number of patients discharged with a plan to be seen and managed by the ESD team.</p> <p>Tolerance: The metric has already taken into account the proportions for whom ESD would not apply such as individuals who are eligible but who decline or who reside outside the UK and those not eligible for clinical reasons. The availability of an Early Supported Discharge team is not a reason to exclude patients from the denominator.</p> <p>Stroke skilled: The RCP definition of specialist stroke team applies in this instance. A specialist team or service is defined as a group of specialists who work together regularly managing people with a particular group of problems (stroke) and who between them have the knowledge and skills to assess and resolve the majority of problems. At a minimum any specialist team or service must be able to fulfil all the relevant recommendations made in the RCP National Clinical Guidelines 2008. The team does not have to manage stroke exclusively but should have specific expertise and knowledge about people with stroke. The spirit of this guidance is that individuals should be managed by stroke specific or neurological rehabilitation teams to whom appropriate stroke patients in a particular area are referred, but not by generic teams who also manage patients with non-neurological conditions as well as stroke and neurology.</p> <p>Early supported discharge service: a comprehensive stroke skilled multidisciplinary team who manage patients at their place of residence and who are able to provide rehabilitation of similar intensity to that of a stroke unit.</p> <p>Composition of the team would usually include a co-ordinator/manager, physiotherapist, occupational therapist, speech and language therapist with support from nursing and social care.</p> <p>Eligibility for ESD: no clinical guidance is yet available but review of the literature and of existing services refers to eligible patients as those able to carry out a functional transfer safely with one, if living with an able carer, or independently if living alone, has a moderate disability (initial Barthel more than 9), and is able to manage other problems safely at home.</p> <p>Patients to be included will be those whom in the opinion of the multidisciplinary team will benefit from early discharge from hospital supported by therapy at home.</p> <p>It would not be appropriate to include patients with no functional deficit, or those who have had a prolonged inpatient stay include patients discharged to services which carry out the functions of an ESD service as described above but who have a different name -assisted or supported discharge team for example. An ESD service should be one component of a stroke specific community rehabilitation service available to stroke survivors on hospital discharge.</p> |

| Rationale | Quality Marker | Pathway Stage | Date Source |
|--|----------------|----------------------------------|--------------------------|
| People who have had strokes either living at home or in care homes, are offered a review from primary care services of their health and social care status and secondary prevention needs, typically at 6 weeks and 5 months after leaving hospital. This is followed by an annual health and social care check. National Stroke Strategy. Ideally the 6 week review would be carried out by a stroke specialist who could be a doctor, or specialist nurse or AHP | 10, 14 | Life after stroke | Rehabilitation, New Data |
| Early Supported Discharge to a comprehensive stroke specialist and multidisciplinary team (which includes social care). In the community but with a similar level of intensity to stroke unit care, can reduce mortality and institution rates. National Stroke Strategy. The best results are likely to be seen with well resourced and co-ordinated ESD teams and with patients with less severe stroke symptoms Langhorne et al 2007 | 10, 12 | Rehabilitation, Transfer of Care | New data |
| | | | |

Appendix: C SINAP pro-forma

**SINAP**

STROKE IMPROVEMENT NATIONAL AUDIT PROGRAMME

*Proforma – Web Tool View***Aims:**

- To describe the pathway followed by patients with acute stroke (in the first three days) in hospitals.
- To assess the quality of care provided to acute stroke patients during the first three days of care.
- To identify the major areas where services need to be improved for acute stroke patients.

Inclusion Criteria for the audit

All patients who elicit a response from the stroke team – although most questions should only be answered for patients diagnosed with stroke (acute ischaemic stroke or primary intracerebral haemorrhage)

Exclusion Criteria

Subarachnoid haemorrhage (I60); Subdural and extradural haematoma (I62); Patients admitted more than 72 hours after the onset of the stroke

The Audit Questions

The audit questions have been refined following meetings of a subgroup of the Intercollegiate Stroke Working Party and are linked to the *National Clinical Guidelines for Stroke*, NICE guidelines and current best evidence.

Registration

Registration for SINAP is via CCAD (this is also the method for obtaining a username and password for the web tool). Please go to www.ncasp.org.uk and click on 'Request User' followed by the SINAP option and enter each user's details. Registration is by hospital rather than trust, so please enter the hospital name rather than the trust name.

Methods of data collection

Prospective audit (N.B. we would encourage all participants to enter data onto the web tool in 'real time')

Clinical involvement and supervision - Each hospital should designate a lead clinician who will have overall responsibility for data quality.

For further information and audit helpdesk queries:

Please contact: The Royal College of Physicians' Stroke Programme

Tel: 020 3075 1335

E-mail: sinap@rcplondon.ac.uk

Section 1: Patient Demographics**Patient Demographics****1.1 Hospital**

YYY, General Hospital

1.2 Patient Audit Number**1.3 Hospital number (Currently excluded from data submission)****1.4 NHS number (Currently excluded from data submission)****(b) No NHS number - Overseas visitor (or armed forces, prisoner)**☐ Overseas visitor**1.5 Surname (Currently excluded from data submission)****1.6 Forename (Currently excluded from data submission)****1.7 Date of birth (dd/mm/yyyy) (Currently will change dd to 15)****1.8 Sex: male/female**☐ male ☐ female**1.9 Postcode of usual address (Currently restricted to first 4 characters)**

Section 2: Onset Admission

OnsetAdmission

2.1 Date and time of onset/awareness of symptoms

(a) Date (dd/mm/yyyy)

(b) Date not known

(c) Time (hh:mm)

(d) Time not known

☐ Date not known

☐ Time not known

☐ NHS Direct

☐ GP or out of hours service

☐ Accident and Emergency

☐ Emergency ambulance service

☐ Transferred for primary treatment

☐ Already in hospital

☐ Other

2.2 Which healthcare professionals were involved prior to admission? (tick all that apply)

If other please specify

2.3 Ambulance Job Number

☐ Patient did not arrive by ambulance

☐ Not known

2.4 Date/time patient arrived in hospital

(a) Date (dd/mm/yyyy)

(b) Time (24 hour clock)

2.5 Date and time the patient was first seen by a member of Stroke Team

(a) Date (dd/mm/yyyy)

(b) Time (hh:mm)

(c) Not seen by member of the stroke team

☐ Not seen by member of the stroke team

2.6 Which was the first ward the patient was admitted to? (Please select only one option)

☐ MAU/Admissions/diagnostic unit

☐ Acute Stroke Unit/Bed

☐ Combined Stroke Unit/Bed

☐ Rehabilitation Stroke Unit/Bed

☐ General/Care of Elderly ward

☐ CCU/HDU

☐ ITU

☐ Other

If other please specify

2.7 Did the patient stay in a designated stroke bed during this episode?

☐ Yes ☐ No

2.7 (a) Date and time patient arrived on designated stroke bed

(a) Date (dd/mm/yyyy)

(b) Time (24 hour clock)

2.8 What was the diagnosis?

☐ Stroke

☐ TIA

☐ Other

Section 3: Casemix**Casemix**

3.1 On the basis of history and examination, did the patient present with any of the following?

- | | |
|---|--|
| (a) Face (weakness/sensory loss) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to assess |
| (b) Arm (weakness/sensory loss) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to assess |
| (c) Leg (weakness/sensory loss) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to assess |
| (d) Dysphasia | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to assess |
| (e) Hemianopia | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to assess |
| (f) Inattention/neglect | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to assess |
| (g) Brainstem/cerebellar signs | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to assess |
| (h) Other | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to assess |

If other, please specify

3.2 Was the patient independent in everyday activities prior to stroke?

☐ Yes ☐ No ☐ Unable to assess

Section 4: Investigations**Investigations**

4.1 What was the initial brain imaging modality?

☐ CT ☐ MRI ☐ Not imaged

4.2 Date and time of first brain imaging

(a) Date (dd/mm/yyyy)

(b) Time (24 hour clock)

4.3 What was the type of stroke?

☐ Infarction
☐ Primary intracerebral haemorrhage

Section 5: Thrombolysis

Thrombolysis

5.1 Was the patient given thrombolysis?

☐ Yes ☐ No

5.1(a) If no, what were the reasons for not giving thrombolysis?

- ☐ None
☐ Haemorrhagic stroke
☐ Thrombolysis not available at all at centre
☐ Patient arrived outside normal thrombolysis service hours
☐ Patient a suitable candidate but unable to scan quickly enough
☐ Patient arrived outside the thrombolysis time window
☐ Patient contra-indicated for thrombolysis due to co-morbidity
☐ Patient contra-indicated for thrombolysis due to age
☐ Patient contra-indicated for thrombolysis due to medication
☐ Patient/carer refused
☐ Other

If other, please specify

5.2 Date and time patient was thrombolysed

(a) Date (dd/mm/yyyy)

(b) Time (24 hour clock)

5.3 Was the patient entered into an thrombolysis stroke trial?

☐ Yes ☐ No

5.4 Door to Needle time

5.5 Which grade of clinician made the decision to thrombolysed the patient?

- ☐ Consultant/Associate Specialist physician
☐ Junior doctor
☐ Consultant Nurse
☐ Stroke Specialist Nurse

5.6 Was the decision maker:

- ☐ Present in person
☐ Available via video link
☐ Available via telephone with access to imaging

5.7 What was the specialty of the clinician who made the decision to thrombolysed?

- ☐ Acute physician
☐ Accident & Emergency
☐ Care of the elderly
☐ Stroke physician
☐ Neurologist
☐ Other

If other, please specify

5.8 Did the patient have any complications from the thrombolysis?

☐ Yes ☐ No

5.8(a) If yes, which of the following:

- ☐ Symptomatic Brain haemorrhage ☐ Angio oedema
☐ Extracranial bleed ☐ Other

5.9 Did the patient have a follow-up scan?

☐ Yes ☐ No

If yes:

(a) Date (dd/mm/yyyy)

(b) Time (24 hour clock)

Section 6: 0 – 24 Hours

In Sections 6, 7 and 8, the web tool will enable or disable (grey out) certain questions based on answers to previous questions. If answering on paper first, please be careful not to answer questions which will be disabled on the web tool.

0 - 24 Hours

6.1 Location (tick all that apply) ☐ MAU ☐ ITU ☐ General Medical Ward ☐ Stroke Unit ☐ Other

6.2 Patient condition ☐ Dead ☐ Worse than at presentation ☐ Same as at presentation ☐ Better than at presentation
☐ Full recovery

6.2(a) What was the patient's worst level of consciousness during this period? ☐ Fully conscious
☐ Drowsy
☐ Semi-conscious (not fully rousable)
☐ Unconscious (responds to pain only/no response)

6.3 Palliative care decision ☐ Yes ☐ No

6.4 Was the patient assessed by the following during this 24 hour period? Answer no but... if patient unfit for assessment or no deficit.

(a) Nurse ☐ Yes ☐ No ☐ No but

(b) Occupational Therapist ☐ Yes ☐ No ☐ No but

(c) Physiotherapist ☐ Yes ☐ No ☐ No but

(d) Speech and Language Therapist ☐ Yes ☐ No ☐ No but

6.5 Did the patient receive the following during this 24 hour period? Answer no but... if patient unfit for assessment

(a) Nutrition screening assessment ☐ Yes ☐ No ☐ No but

(b) Formal swallowing assessment ☐ Yes ☐ No ☐ No but

(c) Seen by stroke consultant or associate specialist ☐ Yes ☐ No

6.6 Was the prognosis/ diagnosis discussed with relatives/carer in this 24 hour period? Answer no but... if relative, carer or patient refused or no carer available ☐ Yes ☐ No ☐ No but

6.7 Was oxygen saturation less than 95%? ☐ Yes ☐ No ☐ Not assessed

6.7(a) If yes, was oxygen given? Answer no but... if contra-indicated ☐ Yes ☐ No ☐ No but

6.8 How frequently were neurological observations made during this 24 hour period? ☐ Hourly or more frequently ☐ 2-3 hourly ☐ 4 hourly ☐ 5-12 hourly ☐ 13-24 hourly ☐ No neurological observations during this period

6.9 Was the patient given an antiplatelet during this period? Answer no but... if contra-indicated. ☐ Yes ☐ No ☐ No but

6.10 Did the patient receive more than 1 litre fluid during this 24 hour period? ☐ Yes ☐ No ☐ Not known

6.11 Did the Patient receive adequate nutrition during this 24h period? ☐ Yes ☐ No ☐ Not known

6.12 Did the patient have an indwelling catheter during this period? ☐ Yes ☐ No

6.12(a) If yes, reason for catheterisation: ☐ Retention of urine ☐ Incontinent ☐ Critical skin care ☐ Pre-existing catheter ☐ Fluid balance monitoring ☐ Other ☐ Not documented

6.13 Has a continence plan been drawn up in this 24 hour period? Answer no but... if patient is continent or unconscious ☐ Yes ☐ No ☐ No but

6.14 Was the patient discharged from this hospital during this 24 hour period? ☐ Yes ☐ No

6.15 Other major interventions during the first 24 hours: ☐ None ☐ Intraarterial thrombolysis ☐ Clot retrieval

6.14: If Yes, do not answer sections 7 and 8

Section 7: 24 – 48 Hours

24 - 48 Hours

| | | |
|---|--|---|
| 7.1 Location (tick all that apply) | <input type="checkbox"/> MAU <input type="checkbox"/> ITU <input type="checkbox"/> General Medical Ward <input type="checkbox"/> Stroke Unit <input type="checkbox"/> Other | |
| 7.2 Patient condition | <input type="checkbox"/> Dead <input type="checkbox"/> Worse than at presentation <input type="checkbox"/> Same as at presentation <input type="checkbox"/> Better than at presentation <input type="checkbox"/> Full recovery | |
| 7.2(a) What was the patient's worst level of consciousness during this period? | <input type="checkbox"/> Fully conscious <input type="checkbox"/> Drowsy <input type="checkbox"/> Semi-conscious (not fully rousable) <input type="checkbox"/> Unconscious (responds to pain only/no response) | |
| 7.3 Palliative care decision | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7.3: Do not answer this question if 6.3 = Yes |
| 7.4 Was the patient assessed by the following during this 24 hour period? Answer no but...if patient unfit for assessment or no deficit. | | |
| (a) Nurse | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | 7.4: Do not answer for any part (a – d) for which 6.4 (a – d) = Yes |
| (b) Occupational Therapist | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| (c) Physiotherapist | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| (d) Speech and Language Therapist | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| 7.5 Did the patient receive the following during this 24 hour period? Answer no but...if patient unfit for assessment | | |
| (a) Nutrition screening assessment | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | 7.5: Do not answer for any part (a – c) for which 6.5 (a – c) = Yes |
| (b) Formal swallowing assessment | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| (c) Seen by stroke consultant or associate specialist | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 7.6 Was the prognosis/ diagnosis discussed with relatives/carer in this 24 hour period? Answer no but...if relative, carer or patient refused or no carer available | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | 7.6: Do not answer this question if 6.6 = Yes |
| 7.7 Was oxygen saturation less than 96%? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assessed | |
| 7.7(a) If yes, was oxygen given? Answer no but...if contra-indicated | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| 7.8 How frequently were neurological observations made during this 24 hour period? | <input type="checkbox"/> Hourly or more frequently <input type="checkbox"/> 2-3 hourly <input type="checkbox"/> 4 hourly <input type="checkbox"/> 5-12 hourly <input type="checkbox"/> 13-24 hourly <input type="checkbox"/> No neurological observations during this period | |
| 7.9 Was the patient given an antiplatelet during this period? Answer no but...if contra-indicated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | 7.9: Do not answer this question if 6.9 = Yes |
| 7.10 Did the patient receive more than 1 litre fluid during this 24 hour period? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known | |
| 7.11 Did the Patient receive adequate nutrition during this 24h period? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known | |
| 7.12 Did the patient have an indwelling catheter during this period? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 7.12(a) If yes, reason for catheterisation: | <input type="checkbox"/> Retention of urine <input type="checkbox"/> Incontinent <input type="checkbox"/> Critical skin care <input type="checkbox"/> Pre-existing catheter <input type="checkbox"/> Fluid balance monitoring <input type="checkbox"/> Other <input type="checkbox"/> Not documented | |
| 7.13 Has a continence plan been drawn up in this 24 hour period? Answer no but...if patient is continent or unconscious | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | 7.13: Do not answer this question if 6.13 = Yes |
| 7.14 Was the patient discharged from this hospital during this 24 hour period? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7.14: If Yes, do not answer section 8 |

Section 8: 48 – 72 Hours

| | | |
|---|--|--|
| 8.1 Location (tick all that apply) | <input type="checkbox"/> MAU <input type="checkbox"/> ITU <input type="checkbox"/> General Medical Ward <input type="checkbox"/> Stroke Unit <input type="checkbox"/> Other | |
| 8.2 Patient condition | <input type="checkbox"/> Dead <input type="checkbox"/> Worse than at presentation <input type="checkbox"/> Same as at presentation <input type="checkbox"/> Better than at presentation <input type="checkbox"/> Full recovery | |
| 8.2(a) What was the patient's worst level of consciousness during this period? | <input type="checkbox"/> Fully conscious <input type="checkbox"/> Drowsy <input type="checkbox"/> Semi-conscious (not fully rousable) <input type="checkbox"/> Unconscious (responds to pain only/no response) | |
| 8.3 Palliative care decision | <input type="checkbox"/> Yes <input type="checkbox"/> No | 8.3: Do not answer this question if 6.3 or 7.3 = Yes |
| 8.4 Was the patient assessed by the following during this 24 hour period? Answer no but...if patient unfit for assessment or no deficit. | | 8.4: Do not answer for any part (a – d) for which 6.4 or 7.4 (a – d) = Yes |
| (a) Nurse | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| (b) Occupational Therapist | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| (c) Physiotherapist | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| (d) Speech and Language Therapist | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| 8.5 Did the patient receive the following during this 24 hour period? Answer no but...if patient unfit for assessment | | 8.5: Do not answer for any part (a – c) for which 6.5 or 7.5 (a – c) = Yes |
| (a) Nutrition screening assessment | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| (b) Formal swallowing assessment | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| (c) Seen by stroke consultant or associate specialist | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 8.6 Was the prognosis/ diagnosis discussed with relatives/carer in this 24 hour period? Answer no but...if relative, carer or patient refused or no carer available | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | 8.6: Do not answer this question if 6.6 or 7.6 = Yes |
| 8.7 Was oxygen saturation less than 95%? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assessed | |
| 8.7(a) If yes, was oxygen given? Answer no but...if contra-indicated | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | |
| 8.8 How frequently were neurological observations made during this 24 hour period? | <input type="checkbox"/> Hourly or more frequently <input type="checkbox"/> 2-3 hourly <input type="checkbox"/> 4 hourly <input type="checkbox"/> 5-12 hourly <input type="checkbox"/> 13-24 hourly <input type="checkbox"/> No neurological observations during this period | |
| 8.9 Was the patient given an antiplatelet during this period? Answer no but...if contra-indicated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | 8.9: Do not answer this question if 6.9 or 7.9 = Yes |
| 8.10 Did the patient receive more than 1 litre fluid during this 24 hour period? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known | |
| 8.11 Did the Patient receive adequate nutrition during this 24h period? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known | |
| 8.12 Did the patient have an indwelling catheter during this period? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 8.12(a) If yes, reason for catheterisation: | <input type="checkbox"/> Retention of urine <input type="checkbox"/> Incontinent <input type="checkbox"/> Critical skin care <input type="checkbox"/> Pre-existing catheter <input type="checkbox"/> Fluid balance monitoring <input type="checkbox"/> Other <input type="checkbox"/> Not documented | |
| 8.13 Has a continence plan been drawn up in this 24 hour period? Answer no but...if patient is continent or unconscious | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No but | 8.13: Do not answer this question if 6.13 or 7.13 = Yes |
| 8.14 Was the patient discharged from this hospital during this 24 hour period? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Section 9: Discharge

Section 9 is not mandatory if the patient was not discharged during the first 24 hours (i.e. 6.14, 7.14 and 8.14 are all No).

Discharge

- 9.1 Was the patient entered into a randomised stroke trial? ☐ Yes ☐ No
- 9.2 Did the patient have neurosurgery? ☐ None ☐ Haematoma removal
☐ Hemispherectomy ☐ Other
☐ Ventricular shunting
- 9.3 Was the patient referred to a tertiary centre? ☐ Yes ☐ No
- 9.4 Final discharge destination. ☐ Home/usual place of residence ☐ Bed based intermediate care
☐ Other hospital ☐ Stroke unit at other hospital
☐ Dead ☐ Other

Section 10: Supplementary

Supplementary (*Non mandatory)

10.1 Final date of discharge from stroke unit

10.2 Final date of discharge from hospital

10.3 Did the patient spend more than 90% of their stay on the stroke unit? ☐ Yes ☐ No

10.3(a) If no, please give the reason why the patient was not on the stroke unit for more than 90% of their stay

10.4 Modified Rankin score at 3 months

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6

10.5 If the patient had a TIA, were they high risk? (i.e. ABCD2 score of 4 or more or crescendo TIA) ☐ Yes ☐ No

10.5(a) If high risk TIA, was the patient seen, investigated and treatment initiated within 24 hours? ☐ Yes ☐ No

10.5(b) If low risk TIA, was the patient seen, investigated and treatment initiated within 7 days? ☐ Yes ☐ No

Section 11: User Fields

User Defined Fields ("Non mandatory")

You can use these fields to store data defined by your organisation. Each field can contain up to 64K bytes of plain text or numbers. To rename the field titles to something more meaningful, click the 'Rename User Fields' button below. These values will be stored for future reference.

| | | | |
|---------------|----------------------|---------------|----------------------|
| User Field 1 | <input type="text"/> | User Field 17 | <input type="text"/> |
| User Field 2 | <input type="text"/> | User Field 18 | <input type="text"/> |
| User Field 3 | <input type="text"/> | User Field 19 | <input type="text"/> |
| User Field 4 | <input type="text"/> | User Field 20 | <input type="text"/> |
| User Field 5 | <input type="text"/> | User Field 21 | <input type="text"/> |
| User Field 6 | <input type="text"/> | User Field 22 | <input type="text"/> |
| User Field 7 | <input type="text"/> | User Field 23 | <input type="text"/> |
| User Field 8 | <input type="text"/> | User Field 24 | <input type="text"/> |
| User Field 9 | <input type="text"/> | User Field 25 | <input type="text"/> |
| User Field 10 | <input type="text"/> | User Field 26 | <input type="text"/> |
| User Field 11 | <input type="text"/> | User Field 27 | <input type="text"/> |
| User Field 12 | <input type="text"/> | User Field 28 | <input type="text"/> |
| User Field 13 | <input type="text"/> | User Field 29 | <input type="text"/> |
| User Field 14 | <input type="text"/> | User Field 30 | <input type="text"/> |
| User Field 15 | <input type="text"/> | User Field 31 | <input type="text"/> |
| User Field 16 | <input type="text"/> | User Field 32 | <input type="text"/> |

Appendix D: List of documents reviewed

Via NHS London website

| No | Date | Title | Description |
|----|------|--|--|
| 1 | 2008 | Overview of contents | Information for hospitals bidding for new stroke services |
| 2 | 2008 | Bid checklist | Aid to bidders to co-ordinate their bid submission. |
| 3 | 2008 | Background information | This paper provides background information relevant to the designation of acute stroke services across London |
| 4 | 2008 | Overview of designation process | This paper provides an overview of the different stages of the designation process, which will determine the configuration of providers that will deliver London's acute stroke services |
| 5 | 2008 | Guidance on the designation process | This paper provides guidance to potential providers of acute stroke services on the designation process |
| 6 | 2008 | Evaluation process | Description of factors to be used to assess bids |
| 7 | 2008 | Overview of commissioning and finance arrangements | This paper sets out what the commissioning and finance arrangements will be for implementing acute stroke services within London. |
| 8 | 2008 | Designation criteria for provision of a HASU service | This designation criteria document outlines the service specification required to be met by providers intending to bid for the future provision of a hyper acute stroke unit (HASU) service |
| 9 | 2008 | Designation criteria for provision of an SU service | This designation criteria document outlines the service specification required to be met by providers intending to bid for the future provision of a stroke unit (SU) service |
| 10 | 2008 | Designation criteria for provision of a TIA service | This designation criteria document outlines the service specification required to be met by providers intending to bid for the future provision of a transient ischaemic attack (TIA) service. |
| 11 | 2008 | Preliminary acute stroke strategy for London | This document sets out the preliminary acute stroke strategy for London. Its purpose is for wider engagement and discussion with commissioners, service providers and other key stakeholders, before a stroke strategy incorporating prevention, acute and community rehabilitation is published in autumn 2008. |
| 12 | 2008 | Preliminary acute stroke strategy for London: cover note | Sets out the rationale behind the strategy |
| 13 | 2009 | Pan-London high level guidance for stroke protocols | High level guidance on stroke protocols, based on the best available evidence, with particular |

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| | | | emphasis placed on issues that may be difficult to resolve on a network level. |
| 14 | 2008 | Patient flows for each London PCT | This analysis provides a breakdown of predicted stroke patient flows for 2008. It details stroke events, mimics, hospitalisations, SU and HASU death, survivors and bed days that could be expected for London PCTs and the main non-London PCTs. |
| 15 | 2008 | Summary of the London consultation feedback | This document contains extracts taken from the Report on the Consulting the Capital and sections that cover the proposals to create a number of specialist stroke services in London |
| 16 | 2008 | London Health Commission inequalities and equalities impact assessment | This paper analyses the incidence of stroke among different equality groups, detailing the main findings relating to acute stroke services and making recommendations relating to stroke pathways. |
| 17 | 2008 | Summary of sentinel audit, National Stroke Strategy and draft NICE guidelines | This paper briefly highlights the key documents on which the Stroke Strategy draws (the Sentinel Audit, National Stroke Strategy and draft NICE guidelines). |
| 18 | 2008 | Scale of the problem | This paper gives an overview of the incidence, implications and costs of stroke in the UK. |
| 19 | 2008 | Panel membership | This paper details the membership of the following groups; Stroke Project Board, Clinical Expert Panel, Commissioning and Finance Panel, Patient and Carer Panel. |
| 20 | 2008 | Key deliverables | Information now included in the main document |
| 21 | 2008 | Summary of the as-is assessment | This paper summarises the key themes that were drawn from an assessment of the current acute stroke care system in London. |
| 22 | 2008 | Summary of the three main stroke patient pathways | This set of diagrams describes the current stroke patient pathways for Thombolysis, non-Thrombolysis and TIA care |
| 23 | 2008 | Costs of acute stroke services broken down by PCT | Detailed figures of costs based on available HRG information for London PCTs. |
| 24 | 2008 | Summary of approach to modelling | This paper explains in detail the derivation of the model used by the stroke team to generate the detailed analysis around stroke incidents. |
| 25 | 2008 | Scope of financial assessment of stroke services | This paper outlines the various approaches and assumptions used in identifying the costs of acute stroke care in London currently and what further work is required. |

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|----|---|---|---|
| 26 | 2008 | Breakdown of the 2006 Sentinel Audit for London hospitals | This table contains key summary data by NHS Trust from the 2006 Sentinel Audit for London Hospitals. |
| 27 | 2008 | Analysis of current state of stroke services | This paper documents the analysis of current stroke service provision, identifying specific challenges, tracking problems and examples of good practice. |
| 28 | 2006 – present ed with this data 2008 | Ontario model of hyper acute stroke care | Healthcare Quarterly (2006) academic paper |
| 29 | 2008 | High-level stroke pathway | This diagram is drawn from the National Stroke Strategy and highlights the Quality Markers across the acute pathway relating to the awareness, diagnosis and treatment phases of the pathway. |
| 30 | 2008 | Performance standards | This paper focuses on the performance standards for the Acute part of the pathway for patients undergoing thrombolysis; patients not undergoing thrombolysis; and, TIA patients. |
| 31 | 2008 | Service specifications | This paper outlines detailed service specifications for each stage in the acute stroke patients pathway. The new model of care for stroke will require providers to meet these service specifications |
| 32 | 2008 | Challenges mapped by the new model | This paper highlights the key challenges identified for the implementation of the new model. |
| 33 | 2008 | Range of configuration options | Details of the three proposed models for the configuration of acute stroke services in London |
| 34 | 2008 | Evaluation criteria process | Process for developing a set of criteria to evaluate the various potential models for stroke services as well as evaluate the locations for the new services. Includes the list of criteria. |
| 35 | 2008 | Commissioning responsibilities | Outlines the expected commissioning responsibility for the various levels in the system for Pan London, Sector and PCT. |
| 36 | 2008 | Proposed role of the London stroke networks | Outlines the role of the London stroke networks in: clinical leadership, quality, innovation, education and training and audit going forwards |
| 37 | 2008 | Patient and carer involvement | This paper details the proposed mechanisms for securing robust engagement with patients and carers both during the consultation phase for this strategy, and for future service delivery. |
| 38 | 2008 | Challenges gap assessment | This paper maps the gap between the current services and the new model of care identified. A |

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| | | | list of actions is outlined to ensure effective implementation. |
| 39 | 2008 | Service specification and benefits realisation | Outlines how the benefits realisation framework matches the Service Specification to the Evaluation Criteria. It describes a clear schedule of metrics to be generated to ensure the full benefits of the new service are realised. |
| 40 | Oct 2011 | Cost-effectiveness analysis of the London Stroke Service | Report by Prof Stephen Morris et al (UCL) to evaluate cost-effectiveness of new model |
| 41 | | Commissioning and finance framework presentation | Presentation explaining how new London uplift tariff will function and potential pitfalls alongside measures built into counter these – i.e. HASU payments cease after 5 days on HASU to incentivise Trusts not to game the system |
| 42 | 2012 | Healthcare for London: reflections on leadership, lessons and legacy | NHS London publication explaining and reflecting on the Healthcare for London work |
| 43 | November 2009 | Stroke Rehabilitation Guide: supporting London commissioners to commission quality services in 2010/11 | Sets out recognition that acute care has dominated and sets out key performance markers for in-patient, and post in-patient care |
| 44 | Nov 2008 | London stroke strategy web version | Includes in appendix 2 performance standards for prevention, HASU, SU, TIA, IP rehab, community rehab, GP care, voluntary sector |
| 45 | 2010 | NAO report for DH – progress in improving stroke care | Details update in practice since the 2005 report |
| 46 | 2008 | Stroke designation round clarification of questions | FAQs resolved for bidders |
| 47 | Dec 2009 (Commissioning support for London) | Stroke acute commissioning and tariff guidance | This document provides guidance on the commissioning and tariff arrangements associated with the new acute stroke system in London. It summarises the case for change, model of care and the process undertaken to designate units. It then outlines the framework developed to encourage the correct system behaviours in order to achieve the intended benefits. |
| 48 | 2008 | Quantum for stroke by provider and PCT | Cost of stroke by provider by PCT - NHS and London providers only. |
| 49 | May 2010 (Commissioning support) | Stroke continuous professional development project Final report | Non-medical staff training requirements review and recommendations |

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|----|--------------------|--|---|
| | for London) | | |
| 50 | May 2010 | TOR Stroke Clinical Reference Group | Sets out terms of reference and governance for pan-London Stroke CAG |
| 51 | Jan 2009 | Consultation on developing new, high- quality major trauma and stroke services in London | Consultation document draft for public |
| 52 | 2009 | NCAT stroke report | Review of the external clinical panel by NCAT prior to recommendations going out for public consultation – based on interviews with key stakeholders, judging strength of the clinical case, sustainability of plans, support of clinicians, what more could be done to improve the processes – major recommendation is increased clinical support in the roll out of the new configuration. |
| 53 | 2009 (2006) | Provincial Status Report: Ontario Stroke System | May 2006 report reviewing the successes and challenges of the Ontario Stroke System with learning points for the London team |
| 54 | 2008 | Stroke Project Governance | Document setting out key roles needed for the various reconfiguration panels |
| 55 | 2009 | Stroke Implementation Options PPT | Presentation listing options available for supporting implementation programme in the light of the low quality of bids received from many providers – recommends interventional commissioning approach and close clinical monitoring |
| 56 | ?2008 | Stroke Incidence PPT | Presentation by M Wilson documenting how the HCfL stroke model is composed of a composite of; population predictions, stroke incidence data, stroke type data, re-occurrence rates – led to two models – one based on population model (LSE), the other based on activity/finance data (HES) – these were merged to provide the number of stroke beds recommended by the model. |
| 57 | 2008 (2006) | Time is Brain; Saver, J. | Academic article from <i>Stroke</i> – classic paper arguing for stroke to be treated as an emergency condition |
| 58 | 2009 | Appendix 1: Decision making processes and criteria to be used by the JCPCT to agree future service provision arrangements | Document which sets out the criteria by which the decision making processes it will adopt to agree future service provision arrangement. <input type="checkbox"/> the specific criteria it will utilise to determine the future service delivery configuration. |

| | | | |
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| 59 | 2009 | Briefing paper for PCT boards | <p>This report and its appendices detail the key processes adopted in relation to <i>The shape of things to come</i> – a consultation on improving stroke and major trauma care in London. It also provides information regarding the responses received from the public, NHS organisations and key stakeholders.</p> <p>Focus on workforce, implementation, IT, finance and commissioning, whole pathway change, evaluation</p> <p>Of note – negative impacts of stroke reforms are discussed – point viii p23 – suggests that focus on stroke prioritisation may impact negatively on other (non-stroke) patients</p> |
| 60 | 2009 | Board cover sheet for PCTs | Advice for board on ' <i>The shape of things to come</i> ' |
| 61 | 2009 | The shape of things to come | Public consultation document which sets out the main arguments for and against the plans for trauma and stroke reconfiguration (including preferred plans etc) and invites consultation from the public |
| 62 | 2009 | Top-line consultation responses | Basic breakdown of consultation results |
| 63 | 2009 | London councils, councillors and overview & scrutiny committees consultation responses | Council by council response to the trauma and stroke proposals – uncontroversially, where services are upgraded they are supported, where downgraded they are not. Most councils agree with the general thrust of specialisation however |
| 64 | 2009 | London Commercial Organisations Consultation | 2 responses – from a Somali health promotion community organisation in W London, and from 'perfect chicken' |
| 65 | 2009 | LAS response | Well written document putting the position of the LAS in context – generally supportive of both trauma & stroke plans |
| 66 | 2009 | London faith organisations responses | Various faith groups responses |
| 67 | 2009 | PCTs consultation responses | Responses broken down by PCT |
| 68 | 2009 | Health providers and commissioners responses to consultation | Responses broken down by providers and commissioners (including non-London sites) – again, the sense is that where options suit local providers/commissioners they are supported – where not they are not. Some responses are more detailed than others – for instance the response from King's Health Partners is particularly impressive – citing the Heuschmann et al paper on SU size and questioning the logic of co-location. |
| 69 | 2009 | Local medical committees consultation responses | GP responses – short and positive |

| | | | |
|----|------|--|---|
| 70 | 2009 | MPs, Mayors & London Assembly responses | Overall generally supportive of the thrust to centralise – but with questions over locations – particularly where their own (constituents’) interests are impaired by loss of service. A Lansley’s response is of note as parliamentary stroke group chair, and soon to be Health Secretary – a real dislike of the plan to focus on 8 HASUs (questions the evidence based behind this), and desire for any provider willing to meet criteria to be included – and also backs RFH & St T. Seems apparent that under him, coordinated planned rationalisation would not be in vogue. |
| 71 | 2009 | Patient, public & voluntary representative organisations | Interesting local and elderly focus – for example, Age Concern Haringey response talks about transport links for elderly residents – cut off from hi-tech EBM discourse |
| 72 | 2009 | Professional & trade bodies consultation responses | Again generally supportive – states case for rehab to be more prominent, alongside specific issues to do with recruitment, staffing/banding, and evidence behind certain interventions. Articulates need for more thought around community care |
| 73 | 2009 | Responses received outside the consultation period | A number of late responses are presented here |
| 74 | 2009 | Beyond the bath board: vocational rehabilitation | PPT |
| 75 | 2009 | Community care event presentation | PPT |
| 76 | 2009 | Community Rehab best practice | PPT |
| 77 | 2009 | Conceptualising stroke rehab | PPT |
| 78 | 2009 | CPD event Andrew Jackson | PPT |
| 79 | 2009 | CPD event Health Professions Council | PPT |
| 80 | 2009 | CPD event Kingston University | PPT |
| 81 | 2009 | CPD event Stroke Association | PPT |
| 82 | 2009 | CPD event Tony Rudd | PPT – interesting slide around ‘transforming/specialising stroke services’ |
| 83 | 2009 | Defined review best practice | PPT – pilot studies of different community rehab regimes |
| 84 | 2009 | ESD best practice | PPT |
| 85 | 2009 | Financing stroke community rehab | PPT |
| 86 | 2009 | Integrating health social care and the voluntary | PPT |

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|----|------|---|--|
| 87 | 2009 | Introduction to stroke rehab commissioning guidance | PPT |
| 88 | 2009 | National Stroke Strategy direction of travel | PPT – R Boyle presentation – useful – especially ‘direction of travel slide’ |
| 89 | 2009 | Overview of commissioning and finance arrangements | PPT |
| 90 | 2009 | Structuring quality rehab services | PPT |
| 91 | 2009 | Support structures best practice | PPT |

Via Kenworthy/observations

| | | | |
|----|------|----------------|---|
| 92 | 2010 | LMDS | Description of London Minimum Data Set criteria |
| 93 | 2010 | SINAP criteria | Description of SINAP criteria |
| 94 | 2010 | SINAP web-tool | Web tool for collation of SINAP data |

Via UCL research team (JCPCT documents):

| | | | |
|----|-----------|--|---|
| 95 | July 2009 | Integrated Impact Assessment Pan London Acute Stroke Services | Appendix A: Integrated Impact Assessment Matrix Appendix B: Details on the Stakeholder Workshop Event Appendix C: Qualitative Access Review Appendix D: Carbon Assessment Assumptions and Emission Factors Appendix E: Stroke Access Assessment Maps Appendix F: Carbon Assessment Detailed Results and Context Data Appendix G: Further Analysis on Hyper-Acute Stroke Unit Pairings |
| 96 | 27/01/09 | JCPCT agenda item 10- Consultation on stroke & trauma service development | Committee asked to approve the consultation document |
| 97 | 27/01/09 | JCPCT agenda item 11- Consultation strategy on stroke & trauma service development | Committee asked to approve the consultation strategy |
| 98 | 27/01/09 | JCPCT agenda item 2- remit of JCPCT | This paper explains the basis on which the JCPCT has been established, the terms of reference of the JCPCT, the arrangements for chairing the JCPCT and the standing orders to be followed by the JCPCT. |

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| 99 | 27/01/09 | JCPCT agenda item 4- purpose of meeting | This paper provides an overview of: · the purpose of the meeting; · the development of the options presented; · the content of the pre-consultation business case; · the options proposed for consultation; · the consultation process, · and details the key decisions which need to be made. |
| 100 | 27/01/09 | JCPCT agenda item 4- Supporting papers and information previously received by the JCPCT | The JCPCT has received a range of supporting information and papers at its informal meetings leading up to its formal meeting on 27th January 2009. These papers include travel time methodology, designation process overview, incidence of stroke in London, principles and good practice in developing options for consultation, and an implementation framework. |
| 101 | 27/01/09 | JCPCT – power point by SRO – Implementation options for stroke | Highlights findings from bid evaluation and plans for implementation – interesting point re poor bids and lack of management support – need for external support |
| 102 | 27/01/09 | JCPCT agenda item 6 – criteria to be used by JCPCT to agree options for public consultation | Outlines proposed criteria |
| 103 | 27/01/09 | JCPCT Jan 2009 meeting notes | The above documents are ratified |
| 104 | 27/01/09 | JCPCT meeting Jan 2009 – pre-consultation business case | The Pre-Consultation Business Case details the case for change, the process to determine the options, the financial issues and the benefits expected |
| 105 | Jan 2009 | Stroke Services presentation | Short presentation by SRO – interesting as makes arguments around co-location with Trauma |
| 106 | 20/07/09 | Report of the outcomes of consultation and recommended decisions for the Joint Committee of PCTs | Description of the work of the project team in designing and conducting the consultation for both stroke and trauma |
| 107 | July 2009 | JCPCT July 2009 meeting notes | This is the important meeting where the HASU, SU & TIA service site selection is made by the JCPCT |
| 108 | July 2009 | Stroke Incidence presentation | Short presentation re stroke incidence in London |
| 109 | | Communications activity report | Report on distribution of documentation for consultation |

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| 110 | 22/01/09 | Healthcare for London Consultation strategy for stroke and major trauma services in London | This strategy is a 'blueprint' for the Healthcare for London consultation with stakeholders on acute stroke and major trauma services in London. The strategy follows good communications practice and focuses on what will be meaningful to our stakeholders, as opposed to the production and promotion of project outputs. |
| 111 | | Evaluation assurance plan Major trauma and stroke | This paper outlines proposals to take forward an evaluation planning framework for the new trauma and stroke systems with primary care trusts (PCTs), the London trauma director and the London stroke medical director. As such, it forms part of the assurance process to support the decision-making of the Joint Committee of Primary Care Trusts (JCPCT) following consultation on the options for major trauma and acute stroke services across London. |
| 112 | 20/07/09 | Developing new, high-quality major trauma and stroke services for London | The material contained in these documents provides an opportunity for the JCPCT to make recommendations to commissioners to ensure we pursue all opportunities to enhance quality and address the risks to successful implementation. The recommendations in this report are primarily based on an assessment of the above reports, by the stroke and trauma project boards and the Clinical Advisory Group. |
| 113 | 09/06/09 | Consultation with traditionally under-represented groups on the 'shape of things to come' | Report done by 'Health Link' to canvass opinions of those often missed by consultations |
| 114 | | Implementation and transition assurance Stroke | This paper sets out the Healthcare for London stroke project board's assurance that the implementation of the preferred configuration (eight hyper-acute stroke units and 21 stroke units and transient ischaemic attack (TIA) services, together with three stroke units with TIA services in north east London), as set out in the consultation <i>The shape of things to come</i> is deliverable. This paper also outlines arrangements which have been agreed to enable smooth transition. |
| 115 | 16/07/09 | Ipsos Mori consultation analysis | Over 70% of individuals responding were in agreement with the proposal as to how stroke care would be provided in the future and agreed that eight hyper-acute stroke units |

| | | | |
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| | | | <p>would provide the best urgent care for stroke patients in London. The major concerns with the proposed idea of eight hyper-acute stroke units surrounded the issue of location, ensuring patients get urgent medical attention.</p> <p>Whilst there was general support for the focus on specialist stroke care from key stakeholder organisations, some expressed concerns that the evidence base for the stroke care proposals was not as compelling as that for specialist major trauma centres.</p> <p>There was concern from some organisations with regards to the proposed location of hyper-acute stroke units (HASUs), particularly in terms of provision in outer London boroughs. The need for greater outer London coverage was mentioned by those organisations representing residents in Barnet and Enfield. However, there was agreement from transport organisations that blue light ambulance travel times could be met.</p> <p>Three in five (61%) respondents were in favour of the proposed configuration of hyper-acute stroke units and three-quarters (75%) were in agreement with the proposed configuration of stroke units and TIA services. Alternative locations for the units were the most frequently mentioned reason for disagreement with the proposed configuration.</p> |
| 116 | June 2009 | Joint Health Overview & Scrutiny Committee (JHOSC) to review Consultation proposals from 'Healthcare for London': "The Shape of Things to Come - Developing New, High-quality Major Trauma and Stroke Services for London" | <p>This report presents the formal response of the Joint Health Overview and Scrutiny Committee (JHOSC) established to consider <i>"The shape of things to come"</i>, the consultation on developing high-quality major trauma and stroke services in London, undertaken by the Joint Committee of Primary Care Trusts (JCPCT) between January and May 2009.</p> <p><i>That the immediate eight HASUs should be seen as the minimum number, and the JCPT should be prepared regularly to review this number and to increase the number if demand justifies it;</i></p> <p>Gives a democratic green light to the plans</p> |

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| 117 | Feb 2009 | Joint Overview and Scrutiny Committee terms of reference | |
| 118 | 2009 | Strategic coherence Stroke and major trauma | <p>The JCPCT utilised 3 criteria when formulating options for inclusion in the public consultation which took place between January and May 2009. One of the criteria was strategic coherence. In applying this criterion the JCPCT developed options which enable co-location of major trauma and hyper acute stroke services and were aligned with the development of Major Acute Hospitals. The committee has indicated that it would wish to utilise strategic coherence as a criterion when formally taking decisions regarding the future configuration of acute stroke and major trauma service provision on July 20th. This paper seeks to clarify the rationale for utilising the strategic coherence criterion and explains how it could be applied in the JCPCT decision making processes.</p> |
| 119 | 30/06/09 | Clinical Advisory Group report Stroke | <p>This report identifies the issues raised during the consultation which, by virtue of their nature and significance, merited consideration by the Clinical Advisory Group (CAG) at its meeting of 26 June 2009. The CAG considered information and assessments made by the Healthcare for London stroke team in respect of these issues.</p> <p>The purpose of this paper is to present to the JCPCT the CAG's views on these issues and the corresponding assessments.</p> <p>This report does not include the challenges made to the preferred location of hyper-acute and stroke unit services proposed in the consultation document; these were not discussed at the CAG following legal advice.</p> |
| 120 | | Commentary on the consultation Stroke | <p>The purpose of this paper is to present the main issues raised during the public consultation on stroke to the JCPCT and the Healthcare for London stroke project's commentary on these issues.</p> |
| 121 | | Deliverability assurance Stroke | <p>This paper forms part of the assurance process to support the decision making of the Joint Committee of Primary Care Trusts (JCPCT) following a period of public</p> |

| | | | |
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| | | | consultation about the proposed configuration of providers of hyper-acute stroke units (HASUs), stroke units (SUs) and transient ischaemic attack (TIA) services. It describes the planning that has taken place which will enable the JCPCT to be confident in designating the new acute stroke service. |
| 122 | | Finance and commissioning assurance plan Stroke | This paper aims to provide assurance to the Joint Committee of Primary Care Trusts (JCPCT) that the proposals for the stroke system are affordable and that plans exist to commission the new stroke services and ensure that the benefits are delivered. |
| 123 | | Information and technology assurance Stroke | The London Programme for Information Technology (LPfIT) and the Healthcare for London stroke project have been working together to examine areas of IT support and infrastructure that could be developed and implemented to underpin and improve the delivery of stroke services in London. These developments are not essential to the functioning of future stroke services but provide an opportunity to develop efficient, high-quality integrated systems. |
| 124 | | Whole pathway assurance paper Stroke | The plans in place to continue work on the non-acute aspects of the stroke pathway allow assurance to be offered that a decision on the future of acute stroke services can be taken. |
| 125 | | Workforce assurance Stroke | This paper gives assurance that there are plans in place to ensure that there will be sufficient workforce in place to enable the implementation of the acute part of the new stroke pathway. |

| PhD work | Year | EIS work |
|--|------------------|--|
| Documentary analysis, literature review Informal discussions with contacts about the stroke reconfiguration | Sept 2009 | Systematic reviews of medical and social science implementation literatures |
| Documentary analysis, literature review Ethical clearance Observations began September (analysis concurrent) | 2010 | Systematic reviews of medical and social science implementation literatures Began international case studies |
| Documentary analysis, literature review PhD upgrade July Case study 1 pilot interviews then formal interviews began in August Case study 2 interviews September- December Interview data analysis concurrent | 2011 | Ongoing international case studies and data analysis Started to write Leadership paper – drawing on Dean framework in early stages |
| Documentary analysis, literature review Observations ended September Ongoing case study 1 interviews – these were completed in 2012 Interview data analysis concurrent | 2012 | Ongoing data analysis, project commitments and paper writing |
| Documentary analysis, literature review Interview data analysis concurrent Writing up status from September | 2013 | Ongoing data analysis, and project commitments and paper writing Teaching role |
| Documentary analysis, literature review Writing up to September | Sept 2014 | Ongoing data analysis and paper writing Teaching role |

Appendix E: PhD & EIS project timeline

Appendix F: PhD Interview schedule

- 1. Introduction**
- 2. Visibility**
- 3. Knowledge**
- 4. Techniques**
- 5. Identity**
- 6. Conclusions/reflections**

Introduction

1. Please tell me a little about your background; i.e. your job title, your role in the organisation, how long you have worked here?
2. Please tell me about how you were involved in the reconfiguration of stroke services in London?
3. In your opinion, what have been the effects of the reconfiguration?

Visibility

4. Why were stroke services identified for reconfiguration?
5. Are all areas of stroke care being reconfigured (i.e. primary care, secondary prevention, community rehab, acute and hyper acute)?
6. How do you know if the reconfiguration is effective?

Knowledge

7. What is the evidence behind the reconfiguration?
8. Where does this evidence come from?
9. Is any of the evidence disputed, and if so, how are disputes resolved?

Techniques

10. What techniques are used to change practice in line with the goals of the reconfiguration?
11. Is there resistance to this, and if so, how is this managed?
12. How do you know these techniques are effective?

Identity

13. How have these changes affected staff?
14. Has clinical autonomy been affected?
15. Is there resistance to this, and if so, how is this managed?

Conclusions/reflections

16. Overall, looking at the reconfiguration, what elements do you think have been most successful/least successful?

Appendix G: EIS project Interview schedule 8 24/11/10**Development of a European Implementation Score for measuring implementation of research into healthcare practice using vascular disease as an example*****Background***

1. Please tell me about your professional position and your current role – how long have you been at this institution and working in your chosen specialty?
2. Do you use evidence based research in your work, and if so, how?
3. Could you provide me with an example of this?
4. Could you provide me with an example of when an evidence based change has failed to be implemented?

Motivation

5. What is the motivation for changing practice to make it more evidence based at a personal level?
6. What is the motivation for changing practice to make it more evidence based at an organisational level?

Implementation

7. What are the enabling factors which over time help the implementation of evidence based research knowledge?
8. What are the restraining factors which over time hinder the implementation of evidence based research knowledge?
9. What are the processes used to make practice more evidence based?

For example what implementation strategies/interventions are used at your institution and how successful do you find them?

Normalisation

10. How do these evidence based changes/best practice become routine practice?

Stroke/job specific

11. Are there any challenges which you find are specific to stroke care in terms of increasing research uptake and transferring this into practice? (Team work – what does this mean in practice?) Secondary prevention?

12. As a nurse/manager/therapist/doctor etc, do you feel you face any particular challenges in increasing research uptake and transferring this into practice?

Questions 7 & 8

- Clear strategic vision
- Good managerial relations
- Visionary staff in key positions (opinion leaders)
- Climate conducive to experimentation and risk-taking (learning organisation)
- Effective monitoring and feedback decisions
- Strength of the evidence
- Resource allocation
- Strong leadership (transformational)
- Extent of change to established work practices

Question 9

- Strategic/organisational approach to implementation (policies/procedures/standards)
- Audit and feedback
- Computerised decision support
- Educational strategies
- Multi-faceted interventions
- Opinion leadership
- User involvement/patient association liaison
- Availability of quality register data

Appendix H: London Stroke Clinical Advisory Group minutes

Tuesday, 3rd April 2012

1. Clinical Advisory Group:

In attendance:

Redacted for purposes
of anonymisation

Guests:

Apologies:

2. Minutes and Matters arising not covered elsewhere in the agenda

- 2.1. Action for TR to write to SU leads re: repatriation of stroke mimics carried forward.
 - 2.2. SSNAP organisational audit update; each service was encouraged to pilot the organisational audit on the paper form published on the RCP website and feedback to the SSNAP development team.
Delays confirming a contract with HQIP continue.
 - 2.3. Minutes of the previous meeting were agreed.
-

3. Feedback from the HASU leads meeting

It was reported as having been a positive meeting. Main discussion focused on the escalation protocol for HASU capacity due to feedback from HASUs and LAS data. As a consequence the protocol would be revised by HW/NT and TR.

It was recognised that there was limited ability to intervene once an ambulance crew had arrive at the scene but that they would try to encourage a shift of journeys for patients from the Chase Farm/Edmonton area to NPH instead of UCH, using the same approach as when crews were encouraged to travel to STH to support capacity at Kings.

This process would be reviewed over the following few months.

Action: TR to feedback as appropriate

4. St. Mary's repatriation audit

Guest attendee, Faye Wilson, presented the results of an audit on the information and details sent by HASUs with patients when they have been repatriated to St. Mary's stroke unit. They based the criteria for the audit of the London transfer protocol document. See presentation, attached with these minutes for details.

Key findings were that only a small proportion of patients were being repatriated with; imaging, a discharge summary and a medical handover. There had also been a significant proportion of patients that were transferred out of hours.

Additionally, the creation of the audit highlighted that the transfer protocol included requirements that were out of date, and revision of the protocol to reflect changes in practice was suggested.

Action: Person to lead on this revision within this group to be identified

5. LAS role in TIA pathways

NT requested that the group consider what the appropriate action for an ambulance crew to take when they suspect a patient has had a TIA.

This group agreed that if the patient has Atrial Fibrillation, reports as having had more than one 'event' in the past week or still has symptoms these patients should be taken to a HASU.

Any patients not taken to a HASU should be provided with (no more than) 2 day's worth of aspirin and informed that they should visit their GP.

6. Review of the standards of performance for acute services

Carried forward to the next meeting

7. Data (RAG) reporting to Board

Stroke services providers had requested that they are able to review these reports prior to their submission to the pan-London cardiac and stroke network board and this proposal was supported by this group.

Action: HW to feed this back to the other Network Directors and to confirm that the schedules for reporting enable sufficient time for these reports to be reviewed.

8. Any other business

8.1. Endovascular approach to acute stroke

The so called consensus document from the Stroke Improvement Programme was noted. Some HASUs are looking to provide endovascular treatments for patients either routinely or as part of a trial. Robust debate was had around whether these services should now be made available to all patients that might benefit or whether there should be an obligation to put patients into RCT's e.g. the PEACE trial. Consensus was not achieved and it was agreed that there should be a separate meeting convened to discuss a London policy. This will be organised for early summer.

Action: TR to coordinate a meeting between the HASU leads and the interventional services

8.2. SSNAP

TR confirmed that the acute data would be locked when a patient record is transferred between services and that the collection of the information at 6 months post stroke was conducted could be locally defined, it was not anticipated that the acute units would be responsible for this part of the record.

8.3. Intensity of therapy

Positive feedback for the RCP's consensus event on the intensity of therapy post stroke.

Future meetings;

Tuesday 12th June 2012 Room LM2 4th Floor, Stephenson House

Tuesday 3rd July meeting Cancelled

Tuesday 7th August 2012 location tbc.

Appendix I: example CAG meeting agenda document

London Stroke Clinical Advisory Group

Tuesday 1st May 15:00 – 17:00
Room LM1 6th Floor, Stephenson House, 75 Hampstead Road

| | | |
|----|---|----------|
| 1. | Welcome and apologies | Redacted |
| 2. | Minutes and matters arising London HASU capacity escalation protocol Endovascular meeting | |
| 3. | Successful patient experience model | |
| 4. | Review of the standards of performance for acute services | |
| 5. | Rehabilitation update | |
| 6. | Standards of performance for rehabilitation services | |
| 7. | Atrial Fibrillation and TIA services | |
| 8. | Any other business | ALL |

Dates of future meetings;

Tuesday 12th June 2012 Room LM2 4th Floor, Stephenson House

Tuesday 3rd July meeting Cancelled

Tuesday 7th August 2012 location tbc.

Attendees;
Redacted

Guests;
Alec Fraser

Apologies:

Appendix J: University ethics letter

Alec Fraser,
Department of Management,
15th February 2011,



Dear Alec,

REP(EM)/10/11-24 – ‘An enquiry in to the role of evidence in influencing the reconfiguration of stroke services in London.’

I am pleased to inform you that the above application has been reviewed by the E&M Research Ethics Panel that FULL APPROVAL is now granted.

Please ensure that you follow all relevant guidance as laid out in the King's College London *Guidelines on Good Practice in Academic Research* (http://www.kcl.ac.uk/college/policyzone/attachments/good_practice_May_08_FINAL.pdf).

For your information ethical approval is granted until 14th February 2012. If you need approval beyond this point you will need to apply for an extension to approval at least two weeks prior to this explaining why the extension is needed, (please note however that a full re-application will not be necessary unless the protocol has changed). You should also note that if your approval is for one year, you will not be sent a reminder when it is due to lapse.

If you do not start the project within three months of this letter please contact the Research Ethics Office. Should you need to modify the project or request an extension to approval you will need approval for this and should follow the guidance relating to modifying approved applications: <http://www.kcl.ac.uk/research/ethics/applicants/modifications.html>

Any unforeseen ethical problems arising during the course of the project should be reported to the approving committee/panel. In the event of an untoward event or an adverse reaction a full report must be made to the Chairman of the approving committee/review panel within one week of the incident.

Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

If you have any query about any aspect of this ethical approval, please contact your panel/committee administrator in the first instance (<http://www.kcl.ac.uk/research/ethics/contacts.html>). We wish you every success with this work.

Yours sincerely

Daniel Butcher

Research Ethics Administrator

Appendix K: University ethics extension letter

Dear Alec,

I am emailing to inform you that your modification extension request for research ethical approval REP(EM)/10/11-24 has now been approved by the Chair of the E&M REP. Your approval has now been extended by two years until 08/12/2013 and I have updated the King's Research Ethics Database with this information.

Best Wishes,

Daniel Butcher

Research Ethics Officer

Arts & Sciences

King's College London

Room K0.58, Strand, London WC2R 2LS

Tel: +44 (0)20 7848 1440

daniel.butcher@kcl.ac.uk

From: Fraser, Alec

Sent: 19 January 2012 17:35

To: Butcher, Daniel

Subject: RE: Extension request - REP(EM)/10/11-24

Please see attached Daniel:

Thanks as ever for your help.

Best wishes, Alec

Alec Fraser
Research Associate in Social Science
Department of Management
King's College London
Franklin Wilkins Building
150 Stamford Street
London
SE1 9NH

Tel 0207 848 4519

From: Butcher, Daniel
Sent: 19 January 2012 16:37
To: Fraser, Alec
Subject: RE: Extension request - REP(EM)/10/11-24

Dear Alec,

You will need to submit a modification request form. Please follow the link below for further details:

<http://www.kcl.ac.uk/innovation/research/support/ethics/applications/modifications.aspx>

Regards,

Daniel Butcher
Research Ethics Officer
Arts & Sciences
King's College London
Room K0.58, Strand, London WC2R 2LS

Tel: +44 (0)20 7848 1440

daniel.butcher@kcl.ac.uk

From: Fraser, Alec

Sent: 19 January 2012 14:40

To: Butcher, Daniel

Subject: Extension request - REP(EM)/10/11-24

Dear Daniel,

I hope you're well.

I wonder if it would be possible to have an extension for another 12 months to the college ethics clearance for this project please?

I have so far performed a number of interviews, but I need to do more over the next few months.

Many thanks, Alec

Alec Fraser

Research Associate in Social Science

Department of Management

King's College London

Franklin Wilkins Building

150 Stamford Street

London

SE1 9NH

Tel 0207 848 4519

Appendix L: Consent form (interviews)

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES (interview)

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.



Title of Study: *'An enquiry in to the role of evidence in influencing the reconfiguration of stroke services in London'*

King's College Research Ethics Committee Ref: REP(EM)/10/11-24

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please tick
or initial

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to the point of publication ☐
- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998. ☐
- The information you have submitted will be published as a report and you will be sent a copy. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications. ☐
- I consent to my interview being recorded. ☐

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed

Date

Investigator's Statement:

I _____

Confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the participant.

Signed

Date

Appendix M Consent form (observations)

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES (observation)

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.



Title of Study: *'An enquiry in to the role of evidence in influencing the reconfiguration of stroke services in London'*

King's College Research Ethics Committee Ref: **REP(EM)/10/11-24**

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please tick
or initial

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to the point of publication ☐
- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998. ☐
- The information you have submitted will be published as a report and you will be sent a copy. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications. ☐
- I retrospectively consent to notes being taken relating to my involvement in these meetings. ☐

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed

Date

Investigator's Statement:

I _____

Confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the participant.

Signed

Date

Appendix N Information sheets (interviews)

INFORMATION SHEET FOR PARTICIPANTS (interview)



REC Reference Number: REP(EM)/10/11-24

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

‘An enquiry in to the role of evidence in influencing the reconfiguration of stroke services in London’

We would like to invite you to participate in this original research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

- This PhD project is an attempt to understand more about the role of evidence in the reconfiguration of stroke services in London in 2009, how the process as a whole was managed and how this fits in with Health Service Research Theory.
- We are recruiting health service employees (clinical and managerial) working in primary, secondary and specialist care.
- If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.
- If you agree to take part, you will undergo a 30-60 minute semi-structured interview. Interviews will be recorded, subject to your permission. Recordings of interviews will be deleted upon transcription.
- The recording will be given a code number (identifiable only to the interviewer) and later externally transcribed.
- There is no risk involved in this study except your valuable time. There is no direct benefit to you also. You will be offered a final copy of the report.

- The information provided by you will remain confidential. Nobody except principal investigator will have an access to it. Your name and identity will also not be disclosed at any time. However the data may be published as part of a journal article and elsewhere without giving your name or disclosing your identity.
- Name and contact details of the researcher: Alec Fraser, Department of Management King's College London on 0207 848 4519. Email: alec.1.fraser@kcl.ac.uk

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw at any time and without giving a reason before 31/12/12.

If this study has harmed you in any way you can contact King's College London using the details below for further advice and information: Dr Juan Baeza, Department of Management King's College London on 0207 848 4634. Email: juan.baeza@kcl.ac.uk, or Alec Fraser, Department of Management King's College London on 0207 848 4519. Email: alec.1.fraser@kcl.ac.uk

Appendix O: information sheets (observations)

INFORMATION SHEET FOR PARTICIPANTS (observation)



KCL ethics Reference Number: REP(EM)/10/11-24

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

‘An enquiry in to the role of evidence in influencing the reconfiguration of stroke services in London’

We would like to invite you to participate in this original research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

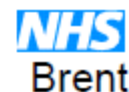
- This PhD project is an attempt to understand more about the role of evidence in the reconfiguration of stroke services in London, how the process as a whole was managed and how this fits in with Health Service Research and Organisational Theory.
- We are recruiting health service employees (clinical and managerial) working in primary, secondary and specialist care and non-health service employees who sit on health service committees.
- If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.
- If you agree to take part, your participation at this meeting will be observed by a researcher who will take notes describing the events of the meeting.
- There is no risk involved in this study except your valuable time. There is no direct benefit to you also. However, you will be offered a final copy of the report.
- The information provided by you will remain confidential. Nobody except principal investigator will have an access to it. Your name and identity will also not be disclosed at any time. However the data may be published as part of a journal article and elsewhere without giving your name or disclosing your identity.

- Name and contact details of the researcher: Alec Fraser, Department of Management King's College London on 0207 848 4519. Email: alec.1.fraser@kcl.ac.uk

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw at any time and without giving a reason before 31/12/12.

If this study has harmed you in any way you can contact King's College London using the details below for further advice and information: Dr Juan Baeza, Department of Management King's College London on 0207 848 4634. Email: juan.baeza@kcl.ac.uk, or Alec Fraser, Department of Management King's College London on 0207 848 4519. Email: alec.1.fraser@kcl.ac.uk

Appendix P Letter of access (observations)



Applied Research Unit
Wembley Centre for Health & Care
116 Chaplin Road
Wembley
Middlesex
HA0 4UZ

Tel: 020 8795 6730/5
Fax: 020 8795 6737

Email: ricky.banarsee@brentpct.nhs.uk

Mr Alec Fraser
Research Associate
King's College London
Department of Management
150 Stamford Street
London SE1 9NH

16th August 2012

Dear Alec Fraser,

| | | |
|-----------------------|---|-------------|
| Project Title: | An enquiry into the role of evidence in influencing the reconfiguration of stroke services in London 2009 | |
| REC | N/A | |
| Portfolio No | N/A | IRAS No N/A |

The West London Primary Care Consortium (for Research and Innovation) has reviewed your proposal.

I am satisfied that your proposal meets with the requirements of the Research Governance Framework (RGF). I am pleased to inform you, on behalf of NHS Westminster, we agree to you using this NHS organisation in order to carry out your research as part of your PhD.

You will carry out observations of the London Stroke Clinical Advisory Group meetings and conduct interviews with its members.

Please note that this does not commit the NHS Trust to ongoing financial support for any intervention trialled. The NHS Trust does not indemnify the research site, the host organisation or the participants in relation to the conduct or management of the research; the responsibility for indemnity arrangements rests with the study sponsor.

Please ensure that you:

1) Report all SUSARs (Serious unexpected serious adverse reaction) to the Research Ethics Committee and any affecting our patients should be reported to Sylvia Westrup. Failure to abide by this will result in the withdrawal of the Trust's approval.

2) Respond to any requests from Brent PCT's, which hosts the audit function, and provide it with any project amendments, project extensions or terminations. PCTs are required by the Research Governance Framework to maintain a comprehensive database of all research projects.

3) Inform us that the study has been completed by sending a copy of the NRES 'Declaration of the End of Study' form (or completing our brief end of study report form which will be emailed to you after the end date), a summary of the final report and the number of patients recruited from NW London primary care who took part in your study.

Chair : Marcia Saunders

Chief Executive : Rob Larkman

4) If your study is on the NIHR CCN Portfolio you are required to report accruals information on a monthly basis to the specified network. This will ensure that the Trust will be allocated the necessary funding from the NW London CLRN.

Attached with this letter are our RGF conditions which you are required to adhere to.

Please do not hesitate to contact Sylvia Westrup, (s.westrup@imperial.ac.uk) if you require further assistance.

With kind regards



Ricky Banarsee
Director WeLReN/Applied Research Unit at Brent PCT

Sent via email

c.c.

Juan Baeza, Department of Management KCL – juan.baeza@kcl.ac.uk

Hilary Walker, Director NW & NC London CardioVascular & Stroke Network – hwalker3@nhs.net

Appendix Q NHS ethics exemption



National Research Ethics Service

St Thomas' Research Ethics Committee
(South London REC Office 3)
Governors' Suite
St Thomas' Hospital
London SE1 7EH

18 May 2010

Alec Fraser
Research Associate in Social Science
Department of Management
King's College London
Franklin Wilkins Building
150 Stamford Street
London, SE1 9NH

Chair: Dr Robert Carr
REC Co-ordinator: Stella Hirsch
Direct line: 020 7188 2257
Fax 020 7188 2258
Email: stella.hirsch@gstt.nhs.uk

Dear Dr Fraser

10/11 EIS – Development of a European Implementation Score for measuring implementation of research into healthcare practice using vascular disease as an example

Thank you for seeking the Research Ethics Committee's (REC) advice on this study.

The information in your correspondence dated 11/03/10 and thereafter, has been considered by the Chairman, Dr R Carr, who has advised the following:

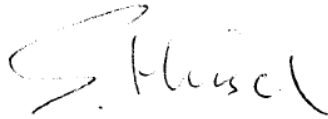
- Work Package 2 and 3 do not involve patients and are not required to be ethically reviewed under the terms of the Governance Arrangements for RECs in the UK.
- As the rest of your PhD work involves those involved in planning health care provision and those delivering the service, but not patients, there is no need for formal REC approval.

As discussed, we look forward to receiving an application for a substantial amendment to EC01/020 (South London Stroke Register) for the necessary REC approval for Work Package 8.

Although review by a Research Ethics Committee is not required, you should check with the R&D Department whether management approval is required before the projects start.

Please note a reference number has been allocated to this study and should be quoted in future correspondence.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'S. Hirsch', with a stylized flourish at the end.

Stella Hirsch
REC Coordinator

Appendix R: EIS project information sheet

INFORMATION SHEET FOR PARTICIPANTS (interview)



REC Reference Number: **REP(EM)/10/11-8**

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Development of a European Implementation Score (EIS) for measuring implementation of research into healthcare practice using vascular disease as an example

We would like to invite you to participate in this original research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

- This collaborative project will develop a European methodology to assess the implementation of research evidence into practice (the European Implementation Score (EIS)) in primary, secondary and specialist care from the perspectives of different target groups (users and carers, voluntary organisations, range of health and social care professionals and health policy makers) using stroke as the main example. The transferability of the developed methodologies to coronary heart disease will be assessed. This work is split in to various Work Packages with specific goals in order to achieve this collaborative aim. The goal of our Work Package is to develop the European Implementation Score (EIS) to estimate the degree of implementation of research evidence into practice.
- We are recruiting health service employees (clinical and managerial) working in primary, secondary and specialist care.
- If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.
- If you agree to take part, you will undergo a 30 minute semi-structured interview. Interviews will be recorded, subject to your permission. Recordings of interviews will be deleted upon transcription.
- The recording will be given a code number (identifiable only to the interviewer) and later externally transcribed.

- There is no risk involved in this study except your valuable time. There is no direct benefit to you also. However, the results of the study may help us to formulate the EIS to measure research implementation in healthcare, and you will be offered a final copy of the report.
- The information provided by you will remain confidential. Nobody except principal investigator will have an access to it. Your name and identity will also not be disclosed at any time. However the data may be seen by EIS team members and may be published as part of a journal article and elsewhere without giving your name or disclosing your identity.
- Name and contact details of the researcher: Alec Fraser, Department of Management King's College London on 0207 848 4519. Email: alec.1.fraser@kcl.ac.uk

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw at any time and without giving a reason before 31/12/11.

If this study has harmed you in any way you can contact King's College London using the details below for further advice and information: Dr Juan Baeza, Department of Management King's College London on 0207 848 4634. Email: juan.baeza@kcl.ac.uk, or Alec Fraser, Department of Management King's College London on 0207 848 4519. Email: alec.1.fraser@kcl.ac.uk

Appendix S: EIS project consent form

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES (interview)

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.



Title of Study: Development of a European Implementation Score (EIS) for measuring implementation of research into healthcare practice using vascular disease as an example

King's College Research Ethics Committee Ref: REP (EM)/10/11-8

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please tick
or initial

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to the point of publication ☐
- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998. ☐
- The information you have submitted will be published as a report and you will be sent a copy. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications. ☐
- I consent to my interview being recorded. ☐

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed

Date

Investigator's Statement:

I _____

Confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the participant.

Signed

Date